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[COMMITTEE PRINT]

# CATASTROPHIC HEALTH INSURANCE: THE "MEDIGAP" CRISIS

## A REPORT

BY THE

CHAIRMAN

OF THE

SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE

OF THE

## SELECT COMMITTEE ON AGING
## HOUSE OF REPRESENTATIVES

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# CONTENTS

## Catastrophic Health Insurance: The "Medigap" Crisis


| | Page |
|---|---|
| Preface | 1 |
| Glossary | 5 |
| Introduction and Executive Summary | 9 |
| I. The Numbers | 17 |
| II. Medicare and its "Gaps" | 20 |
| III. Filling the "Gaps:" Medicare Supplemental Insurance | 36 |
| IV. Abuses in the Sale of Medicare Supplemental Insurance to the Elderly | 55 |
| A. Chronology of Public and Private Activities Relating to Abuses in the Sale of Medicare Supplemental Insurance to the Elderly | 56 |
| B. State Commissioners Confirm Abuses in the Sale of Medicare Supplemental Insurance to the Elderly (1978-present) | 84 |
| C. Subcommittee Investigations Confirm Abuses in the Sale of Medicare Supplemental Insurance to the Elderly—1978 and 1986 | 93 |
| V. Regulation of Medicare Supplemental Insurance by the States: Two Surveys of 50 State Insurance Departments | 112 |
| VI. Efforts at Regulation of Medicare Supplemental Insurance by the Federal Government | 166 |
| A. Department of Health and Human Services | 166 |
| B. Federal Trade Commission | 169 |
| C. Department of Justice | 171 |
| D. U.S. Postal Service | 172 |
| VII. Summary and Conclusions | 175 |
| VIII. Policy Recommendations | 178 |


## IX. Appendixes


| | |
|---|---|
| Appendix A. Sample Questionnaire on Regulation of Health and Medicare Supplemental Policies, Sent February 1984 to All State Commissioners of Insurance | 182 |
| Appendix B. Sample Questionnaire on Regulation of Health and Medicare Supplemental Policies, Sent March 1986 to All State Commissioners of Insurance | 193 |
| Appendix C. Sample Questionnaire to all Area Agencies on Aging to Measure Knowledge Older People Have About Basic Attributes of Health Insurance, May 1986 | 199 |
| Appendix D. Sample Questionnaire to Federal Agencies Responsible for Insurance Matters, Including the U.S. Postal Service, the Federal Trade Commission, the Department of Health and Human Services, and the Department of Justice | 204 |
| Appendix E. Premiums—Claims—Loss Ratios for All Health Insurance Companies, as Taken From the Argus Guide, 1985 Edition | 205 |
| Part I—Ranking by Premium | 205 |
| Part II—Ranking by Loss Ratio | 212 |
| Part III—Ranking Alphabetically | 219 |
| Appendix F. Sample Brochures Detailing Benefits of Medicare Supplemental Insurance Policies Reviewed by the Subcommittee | 226 |
| Appendix G. Analysis of All Medicare Supplemental and Medicare Replacement Insurance Policies as of January 1, 1986, Submitted by the Wisconsin Commissioner of Insurance | 234 |
| Appendix H. P.L. 96-265, June 9, 1980. "Voluntary Certification of Medicare Supplemental Health Insurance Policies" | 260 |
| Appendix I. *American Family Life Assurance Company of Columbus* v. *American Broadcasting Companies Inc., et al., Supreme Court of New York County, New York.* Slip Opinion, May 20, 1986 | 264 |




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# PREFACE

Since its creation in 1974, the House Select Committee on Aging and its Subcommittee on Health and Long-Term Care have been charged with the responsibility of conducting a continuing review of Medicare, the Federal Government's health insurance program for older Americans.

During my chairmanship of the House Select Committee on Aging, I called upon the committee staff to conduct an in-depth investigation into alleged abuse in the sale of Medicare supplementary insurance policies. The committee, in November of 1978, released the findings of its exhaustive investigation in a report entitled, "Abuses in the Sale of Health Insurance to the Elderly in Supplementation of Medicare: A National Scandal." This report documented for the first time the broad scope of abuses in health insurance sold to the elderly. Additionally, the report provided the committee and the Congress with a list of options and policy alternatives from which they could choose to bring about needed reform. On the basis of this report and the committee's findings, the Congress did, in fact, act to curb abuses by enacting legislation outlawing certain forms of abusive sales techniques in the sale of insurance to seniors and creating a voluntary certification program for policies sold in supplementation of Medicare.

It has been almost 8 years since the release of this landmark committee report. It has been 6 years since the passage of this reform legislation. For this reason, I called upon the subcommittee staff in 1984 and 1986 to conduct a review of insurance designed to supplement Medicare to determine whether abuses still persist and what impact, if any, the reform legislation has had in curbing the abuses we uncovered in 1978.

This report concludes that abuses in the sale of insurance to the elderly have not diminished, but in fact have increased; that a new voluntary certification program does little in the way of preventing insurance abuses; and that the States and the Federal Government should take remedial action.

The findings of this report come at a time when the Congress and the administration are looking for ways to remedy the anticipated solvency problems facing the Medicare Program and to improve the protection its seniors receive. Since 1981, the subcommittee has conducted a series of nationwide hearings addressing specifically the crisis in health care currently facing our country. These sessions examined the problem of rising costs and reduced benefits under the Medicare Program. They also examined the solvency of Medicare. Perhaps the most jarring revelation in these nearly one dozen hearings was the lack of coverage under private and public



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health insurance for catastrophic illnesses such as Alzheimer's disease and cancer which may require costly extended care.

For this reason, in 1986, I called upon the Subcommittee on Health and Long-Term Care to commence a series of hearings on catastrophic health insurance for the purpose of developing a legislative proposal designed to both insure the solvency of the Medicare Program for years to come and to provide the much needed coverage for the long, drawn out illnesses such as Alzheimer's disease and many forms of cancer—coverage not currently provided by the Medicare Program or private insurance.

We initiated our series of hearings on catastrophic health insurance in February 1986. Dr. Otis R. Bowen, the newly appointed Secretary of the U.S. Department of Health and Human Services, appeared at that session, describing some of his ideas for reform. President Reagan, just days before our subcommittee hearing, had charged the new Secretary with developing a plan to meet the catastrophic health care needs of Americans of all ages. The subcommittee was encouraged by the President's new initiative, but was discouraged by reports that the administration's catastrophic insurance plan would fall far short of meeting the real bankrupting health catastrophies encountered by Americans. The administration's plan had concentrated on methods of assisting Americans pay hospital bills not paid by Medicare or private insurance. Yet, hearing after hearing by the subcommittee has documented the fact that Medicare and private insurance do a pretty good job covering hospital care. Only about 1 percent of older Americans would benefit from the administration's proposal. Dr. Bowen's testimony before the subcommittee did not discount the subcommittee's finding. Rather, he promised the subcommittee that he would consider all proposals to achieve needed reform during the coming year.

The second in our series of hearings brought testimony from the former Secretary of Health and Human Services, Joseph A. Califano, as well as a noted medical expert from Harvard Medical School, Dr. David Blumenthal. Both confirmed the subcommittee's finding that the real catastrophe for older Americans are bills associated with long, drawn out illnesses, chronic conditions from which the older American will not recover. Such conditions, they said, are bankrupting the chronically ill and their families because of Medicare's shortsighted reimbursement system. They urged the subcommittee to consider a reform measure designed to pay for reasonably priced, high quality health care for all types of illnesses, both in and out of hospital.

A third hearing was held in April 1986, in Chattanooga, TN, on catastrophic health insurance. Here again, the subcommittee heard sad stories of families left destitute after paying for their chronically ill relatives. They told the subcommittee how they felt their Medicare and private insurance would be sufficient to cover their health care costs when that need arose. They found out the hard way that no insurance plan can fulfill that promise when a long-term health catastrophe strikes. They urged the subcommittee to design health insurance protection that would give Americans the peace of mind currently unavailable in the health insurance marketplace.

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"Catastrophic Health Insurance: The 'Medigap' Crisis" is the fourth in our series of hearings. In the development of a comprehensive catastrophic health insurance proposal, it is appropriate that we scrutinize the adequacy of public and private insurance currently available to older Americans.

The good work apparent in the report which follows could not have been possible without the help and support of many people. Most of all, subcommittee staff director Kathleen Gardner Cravedi, subcommittee assistant staff director Melanie Modlin and research director Peter Reinecke had the overall responsibility for directing this inquiry and preparing this report. In addition, Ronald Scheid, Lanny Miller and Robert Joy, detailees to the subcommittee from the U.S. Postal Service, Ronald Schwartz, detailee from the Inspector General's Office of the Department of HHS should be commended for their excellent work with the subcommittee through the duration of the investigation. Mrs. Lillian Simmons, a volunteer to the subcommittee, portrayed an interested senior citizen insurance consumer in the majority of insurance interviews undertaken by the subcommittee. Her contribution in this and numerous other facets of the investigation was invaluable.

Mrs. Margaret Dickson, who had helped the Aging Committee in its original Medigap investigation in 1978, returned as a senior investigator in 1986, for which I thank her.

Special thanks must also go to Laura Hart and William Schloss, interns from Duke University's Institute of Public Policy, and Chin Fa Chen, intern from Brown University, who assisted the subcommittee in all aspects related to the preparation of my report on Medigap abuses. Bill Halamandaris and Val Halamandaris made invaluable contributions during their tenure at the Committee on Aging, as did detailee Dayle Berke, fellow Patricia Butch, and interns Mary McNamara Bennett, Marcia Finkel, Andi Samuels, Bonnie Hogue, Marian Brown, Theresa Johnson, Liz Gatti, Catharine Wilson, Glen Stettin, Eve Subrin, Mark Hickman and Martin Schaeffer. Special thanks also to Rita G. Coleman, who gave up many days of vacation from her job at the National Association for Home Care in order to assist with production. All of these people performed activities in an admirable fashion.

I hope that this report will lead to swift enactment of sorely needed reform measures in the area of supplemental Medicare insurance.

CLAUDE PEPPER, *Chairman.*

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## GLOSSARY

Annual Premium: The total payment required in a year to keep a health insurance policy in force.

Basic coverage: Basic coverage generally provides reimbursement for the major expenses associated with illnesses of limited duration, although benefits for 120 to 365 days of hospital care are not uncommon. It typically limits coverage in terms of the maximum expenses or utilization of each particular service that is insured. A basic plan usually provides coverage for one or more of the following: hospital, inpatient physician visits, surgery, and outpatient diagnostic tests.

Benefit maximum: The limit a policy will pay for for a given benefit. A benefit can be expressed either as a length of time (for example, 60 days of semiprivate hospital room charges), or as a dollar amount (for example, $350 for a certain procedure).

Benefit period, or spell of illness: The period that begins the first day you are confined to a hospital or skilled nursing facility and ends when you have gone 60 days without being readmitted to either type of facility.

Coinsurance or copayment: A percentage of a health expense for which you are responsible after paying the deductible amount. A policy that uses coinsurance typically would pay up to 80 percent of a given expense, and you would pay the remaining 20 percent.

Conditionally renewable: The company will continue insuring you as long as it continues to insure people in your State with the same kind of policy.

Coordination of benefits (COB): A method of integrating benefits payable under more than one health insurance plan so that the insured's benefits from all sources do not not exceed 100 percent of allowable medical expenses.

Customary, usual and reasonable charge: The reimbursement from a private insurance plan is the typical charge for the service in the geographic area, determined on a statistical basis, and making allowance for the complexity of the case, or the amount actually or usually charged by the particular physician if less than the customary and reasonable charge.

Deductible: The amount of covered expenses which must be paid by the insured before benefits are payable by the insurer.

Duration of benefits: Most of these policies pay their cash benefits for 1 to 2 years, as long as you are hospitalized. Some pay for less than 1 year; some for an unlimited duration.

Dread disease policy: A policy providing coverage for a serious illness (most frequently cancer), in which benefits are usually tied to hospitalization that is, a flat fee is paid for each day of hospitalization). For this reason, most dread disease policies do not provide cost-effective insurance protection for senior citizens. The average cancer patient stays in the hospital only 7 days, and is hospitalized



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only 1.8 times in a 2-year period. Therefore, a very small proportion of dread disease patients break even on the money paid in premiums.

Elimination period: Applies to a certain type of plan called a hospital income policy, in which benefits may not be paid under the elimination period for the first several days of hospitalization. Elimination periods vary from policy to policy and from company to company. The result is their length can be selected: the longer the elimination period, the lower the cost of insurance. But one is less likely to receive benefits for a short period of illness.

Entrance age: The age up to which the company will sell you a policy. Entrance ages vary considerably from company to company and some policies can be bought at any age.

Fee schedule: The insurance specifies the maximum dollar amounts that it will pay for a particular service.

First dollar coverage: Insurance plans or portions of plans which provide benefits without first requiring payment of a deductible.

Group policy: Specified benefits are provided to group members, and often their spouses and children, under a contract between the insurer and an organization, such as an employer, a labor union, or a voluntary association.

Guaranteed renewable: The company agrees to continue insuring you up to a certain age as long as you pay the premium; and it cannot raise your premium unless it raises premiums for a particular class, such as everyone in your geographical area with the same kind of policy. Some policies are guaranteed renewable for life.

Health maintenance organization: A community medical service plan. Its annual fee entitles a person to its health facilities, professional services, and supplies. HMO's which accept Medicare members compute the dollar value of your Medicare benefits, plus the value of your supplementary group coverage, and charge you in dollars what it takes to meet their annual fee.

Hospital income policy or hospital indemnity policy: This kind of policy pays its benefits in cash on a daily basis when you are hospitalized. Because Medicare covers most of the cost of up to 2 months of hospitalization, many people set aside the early benefits to these policies against out-of-pocket costs that develop later in a spell of illness.

Licensing: If the company is licensed to sell insurance in your State, you will have recourse to your State insurance commissioner should a dispute arise.

Lifetime maximum: A limit that some plans set on the total benefits they will pay over the life of the policy.

Lifetime reserve: Under Medicare's Hospital Insurance (Part A), benefits for 60 additional hospital days which can be used whenever a beneficiary has exhausted the 90 days covered in a benefit period. In 1986, lifetime reserve days are subject to a copayment of $246 per day.

Major medical coverage: Coverage designed to provide protection associated with more costly illnesses. It usually obligates the insurer to pay a specified portion of a wide range of medical expenses in excess of a deductible and usually is characterized by few internal limits for particular services and a high overall limit.

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Medicare Part A (hospital insurance): The first part of Medicare (part A) is primarily a hospital insurance program. After you pay a deductible amount of $492, Medicare pays for 60 days of full hospital care for each spell of illness, including all of the charges customarily associated with a hospital bill, such as the semiprivate room rate, meals, regular nursing services, laboratory and X-ray fees, meals, intensive care costs, operating and recovery room, drugs, casts, dressings, splints and in-hospital therapy services.

If a spell of illness goes beyond 60 hospital days, you become responsible for a $123 daily copayment, up through the 90th day.

In effect, the program provides for most of the cost of 90 days of hospitalization for each spell of illness.

In addition, the program provides a 60-day lifetime reserve of hospital days against which you can draw, should any spell of illness extend beyond 90 days. You must pay $246 for each day you use the reserve.

Medicare Part A also pays toward extended care in a skilled nursing home, as well as part-time skilled nursing care at home. It works this way:

After a hospital stay of at least 3 consecutive days, Medicare helps pay for up to 100 days of extended care in a skilled nursing facility, provided that the nursing is certified as being connected with the illness that put you in the hospital. As with the hospital coverage, the nursing home benefit pays the charges normally associated with these facilities. The first 20 days of nursing home care are paid in full. The next 80 days of care requires a $61.50 daily copayment from you. Your eligibility depends upon your need for skilled medical services. The program does not cover custodial care in a nursing home.

Medicare Part A also provides for home nursing visits by skilled paramedical personnel. These benefits can include therapy, skilled medical services, and supplies and equipment provided by home health care agencies.

Medicare Part B (medical insurance): The second part of Medicare, the one you pay premiums for, helps pay for physician and surgeon services both in and out of a hospital.

It works this way.

After you have paid a $75 deductible amount, the program will pay for 80 percent of reasonable medical charges; you are responsible for 20 percent of those charges.

The key word here is "reasonable," and Medicare determines what is a reasonable charge. It could be considerably below a physician's normal fee. Some physicians accept that figure but others do not.

So the basic question to ask when seeking medical services is: Will your physician or surgeon accept Medicare "assignment"—that is, accept only what Medicare will pay the doctor?

If your physician accepts Medicare assignment, your out-of-pocket expenses will be: (1) the deductible amount; (2) the 20 percent coinsurance; and (3) the part of the doctor's charges in excess of Medicare's definition of a "reasonable" charge.

Aside from physician and surgeon benefits, Medicare Part B has a number of other benefits—most of them subject to the 20 percent coinsurance.

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Medigap: Insurance purchased to offset the difference between what Medicare pays and the costs of medical care.

Nongroup policy: Provides coverage under a contract directly between the insurer and the insured individual or family obtaining the insurance.

Preexisting condition clause: A health problem you had prior to becoming insured. Policies with preexisting condition limitations will not pay benefits for treatment of prior health problems for a specified period of time.

Primary insured: The person in whose name the insurance is issued or carried, in contrast to any dependents covered by the insurance.

Private health insurance: Any insurance for medical or related expenditures but excluding extra cash coverage (small supplemental payments in the event of hospitalization); medical benefits linked to disease such as stroke or cancer (dread disease); and casualty benefits.

Reinstated benefits: Some policies will restore the lifetime maximum according to a specified schedule during periods when you are not drawing benefits.

Renewable at company option: The company reserves the right to stop insuring you as an individual. However, you cannot be cut off from receiving benefits under the policy in the midst of an illness.

Retirement associations: There are several associations of retired individuals that offer supplementary insurance. Membership fees in these associations are nominal and, in addition to offering insurance plans, they provide other programs of interest to retirees.

Typically, the health insurance plans they offer are wide ranging, permit enrollment regardless of previous health history and have fairly short waiting periods for preexisting conditions.

Waiting period: The period of time that must pass, after you become insured, before the policy will begin to pay benefits for a preexisting condition or certain specified illness.

Wraparound policy: This policy typically pays a high proportion of health expenditures Medicare doesn't pay for: first-day hospital deductible amount of Medicare Part A and the copayments that begin on the 61st hospital day. Such a policy may also pay the $75 deductible associated with Medicare Part B and the 20 percent copayment on physician and medical services you would ordinarily be responsible for.

Wraparound policies typically will pay for a substantial part of a number of other health services not fully covered or not covered at all by Medicare, such as out-of-hospital prescription drugs, medical appliances and equipment.

Often, these policies, in effect, extend the number of hospital days covered under Medicare and they may also pay for the copayments involved in a skilled nursing home day.

Wraparound policies vary somewhat from one another, but generally they fulfill their definition—that is they wrap around and fill in the gaps of Medicare.

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## INTRODUCTION AND EXECUTIVE SUMMARY

In November 1978, the House Select Committee on Aging released the results of its investigation of abuses in the sale of health insurance to the elderly in a hearing entitled, "Abuses in the Sale of Supplemental Insurance to the Elderly." The committee called the problem a national scandal of staggering dimensions. Testimony revealed that some insurance companies and their unscrupulous agents had become merchants of fear. Capitalizing on the anxiety about ever-escalating health costs, they have conspired to sell senior citizens multiple, unneeded, duplicative and therefore, essentially worthless insurance policies in supplementation of Medicare, the national health insurance program for the elderly.

A 444-page committee report, "Abuses in the Sale of Health Insurance to the Elderly in Supplementation of Medicare: A National Scandal," estimated that senior citizens were being taken for as much as $1 billion out of the $4 billion they spent for Medicare supplemental policies each year.

The report concluded that that root cause of the widespread abuse is the fact that senior citizens are afraid. Every day they face the double-edge sword of ever-escalating health care costs and constantly decreasing Medicare coverage. Every day they fear getting sick, going broke, going into a nursing home, or becoming dependent upon loved ones. Motivated by fear, they buy hope in the form of one or more insurance policies, not realizing that there is no policy or combination of policies that they could buy that would plug Medicare's gaping holes and provide them with the comprehensive coverage they desperately want. Understandably, senior citizens are ready victims for fast-talking insurance agents.

The committee found that it was not uncommon for senior citizens to have 3, 5, 10, 30 and in one instance 91 different insurance policies. In the most blatant example to come to the committee's attention, a 76-year-old Illinois woman paid over $50,000 in insurance premiums over 10 years and was forced to remortgage her farm to keep up with the premiums. The saddest part of the story was that most policies contained a clause which said that in the case where an individual has more than one policy, only one will pay.

Both the 1978 hearing and its study zeroed in on the pervasive abuse in insurance policies that claim to supplement Medicare. The study was the first detailed national investigation of this problem. It marked the first time that every State department of insurance and the great majority of companies selling Medicare supplemental insurance policies to the elderly had been surveyed. For the first time, large numbers of senior citizens had been asked about their problems with such policies. In addition, the committee conducted investigations in nine States and the District of Columbia: California, New Jersey, Pennsylvania, Maryland, Illinois, Georgia, Arizona, Delaware, and Virginia—which at the time accounted for half



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of America's 23 million aged. Using volunteer senior citizen investigators, the committee developed firsthand information about how some companies took advantage of the fearful aged.

For example, Margaret Dickson, one of the committee's senior citizen investigators from the District of Columbia, got some unsettling advice from health insurance agents when she asked them to look over her collection of supplementary policies for Medicare.

Mrs. Dickson was overinsured, but most of the agents insisted that she buy even more coverage. Some dismissed her policies as garbage without even looking at them, and pressed her to replace them with as many as eight new overlapping plans. Mrs. Dickson said one agent grilled her about my tax bracket, "my banks, my general financial situation, and then suggested—oh heavens, I cannot say it—euthanasia as a solution to long-term health problems." He also asked her to give him power of attorney over her affairs.

What these agents didn't know was that Dickson, a retired receptionist for the committee chairman, was working with congressional investigators. Her son, who took photographs of the meetings, and the insurance sales trainee sitting in on them, were committee staff investigators.

In 50 such interviews, conducted during the fall of 1978, only 8 agents honestly advised, "Gee lady, I think you've already got too much insurance."

Dickson's case was not unique. Investigators found widespread misrepresentation of what policies pay for, high-pressure sales tactics, agents posing as Federal employees, agents persuading elderly persons to replace adequate policies with new ones just so that he or she could get a higher commission, and companies that paid out very little in benefits compared to the large amounts they collected in premiums.

In addition, the report detailed the activities of four staff investigators who obtained jobs with insurance companies in order to determine whether the abusive marketing practices were company policy.

The study concluded that there were widespread abuses with respect to so-called Medigap insurance policies and the manner is which they were sold to the elderly. It also concluded that there has been a failure to aggressively regulate such abuses by many State Insurance Commissioners. The study likewise concluded that most major insurance companies are not involved in the abuses which filled the report.

The abuses that were found were among the insurance companies who specialized primarily in the sale of individual not group policies. Even then, the most serious problems were generally found among the small and almost anonymous insurance companies that specialized in selling to the elderly.

Following the investigations and hearing by the House Select Committee on Aging, Congressman Claude Pepper introduced H.R. 2602, a bill to curb the proliferation of abuse in the sale of Medigap insurance. The bill, which enjoyed the cosponsorship of 265 Members of Congress, would do the following:

*Establish a program of voluntary certification whereby those policies which meet or exceed Federal minimum standards*

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*could be awarded a Federal seal of approval by the Secretary of Health, Education and Welfare.* The Federal standards were those recommended by the National Association of Insurance Commissioners plus requirements for economic value. To qualify, group policies would have to return at least 75 cents on the premium dollar to the insured in the form of claims, and policies sold to individuals must return at least 60 percent of the premium dollar. The Federal seal would serve to guide senior citizens as to what is and what is not acceptable policy. The certification program would give the competitive advantage to firms with high standards and firms with policies which did not meet Federal minimums would be at a significant disadvantage in their sales. States which have enacted substantially equal or higher standards would be exempt from the program.

*Make it unlawful for agents to indulge in two common abuses: overselling and the government look.* There were no laws prohibiting an agent from deliberately overloading senior citizens with multiple policies or pretending to be from the Medicare program or from using advertising materials displaying the Federal eagle and giving the appearance of an official Government document. These practices would be outlawed under the bill. Violation would be a felony punishable by up to 5 years in jail and/or a $25,000 fine.

*Help the States regulate mail order insurance.* Under current law in 1977, the States could not effectively regulate Medicare supplementary policies which were sold by mail. The proposal would require mail order firms to first file their policies with the commissioner of insurance in the State in which it would be sold and obtain his or her approval before they could mail their policies into that State. Violation would be a felony punishable by up to 5 years in jail and/or a $25,000 fine.

The introduction of H.R. 2602 stirred up a strong lobbying effort against its enactment by opponents in the insurance industry. Even with strong bipartisan support for the reform legislation in the House, efforts to move the bill swiftly on the House side were stalled by effective lobbying forces. Staff of the House Select Committee on Aging met with the staff of Senator Max Baucus (D-Mont.) and former Senator John Culver (D-Iowa) to seek support for movement of the bill on the Senate side. Both Senators agreed to introduce S. 1295, a bill identical to H.R. 2602. Between December 5, 1979 and January 30, 1980, Baucus redrafted his bill to exempt from the certification program health insurance contracts established by employers or labor organizations. Baucus also went along with an amendment making clear that effective State programs could replace Federal certification.

The Baucus bill had strong political appeal and was adopted as an amendment to a Social Security disability bill approved by the Senate January 30, 1980. The House passed its version of the Baucus amendment May 22, 1980. And, on June 9, 1980, the voluntary certification of Medicare supplemental health insurance policies became public law (P.L. 96-265) (See appendix H). Among other things, the new law required that a program of voluntary certification for Medigap policies be established; that overselling and the government look as insurance practices be outlawed; that

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mail order firms be required to first file their policies with the commissioner of insurance in the State in which the policy is sold; and that a study of State regulation of such insurance be undertaken by the Department of Health and Human Services.

It has been 6 years since the enactment of this landmark legislative reform measure. It has been 8 years since the committee's investigation into abuses in the sale of insurance to the elderly. The purpose of this report is to determine the status of the Medicare program in America today, both in terms of its future solvency and its current benefit structure; to identify Medicare's shortcomings and gaps in coverage; to examine the role of private insurance in supplementing Medicare's coverage gaps; to evaluate the effectiveness of the States in regulating the sale of Medicare supplemental insurance; and lastly, to determine whether State and Federal regulatory agencies have done an effective job in eliminating the abusive marketing practices identified in earlier congressional investigations. Ultimately, the questions this report seeks to answer are: How effective has the 1980 reform legislation been in bringing about a reduction in abuse in the sale of supplemental insurance to the elderly? Do abuses persist?

The answers to these questions are immensely important as the Congress and the administration in coming months will be developing legislative proposals to insure Medicare's future solvency and improve its benefit package. As we look to the means for protecting Americans against bankruptcy health catastrophes like Alzheimer's and many forms of cancer—not covered by public or private insurance—we must scrutinze the adequacy and effectiveness of health insurance coverage currently available to our nation's older Americans.

In the course of conducting this inquiry, the subcommittee staff undertook the following steps:

At the chairman's request, prepared and sent to all State commissioners of insurance a detailed 11-page questionnaire designed to ascertain each State's experience in the regulation of Medicare supplemental insurance. Results from this February 1984 questionnaire have been tabulated and appear in section V of this report. The questionnaire itself is reprinted in its entirety in appendix A of this report.

At the chairman's request, prepared and sent to all State commissioners of insurance a 6-page questionnaire to update each State's experience in the regulation of Medicare supplemental insurance. Results from this March 1986 questionnaire have been tabulated and appear in section V of this report. The questionnaire itself is reprinted in its entirety in Appendix B of this report.

Conducted detailed followup telephone interviews with all State departments of insurance in 1983 and 1986.

Reviewed all hearings and reports on this subject by congressional committees and administrative agencies.

Reviewed all books, periodicals, and newspaper articles relating to Medicare supplemental insurance policies in the possession of the Library of Congress.

At the chairman's request, prepared and sent to 647 Area Agencies on Aging a 26-item questionnaire designed to meas-

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ure the knowledge older people have about the basic attributes of health insurance. Each AAA was to administer the questionnaire to 1 senior center within their geographic reach, with no fewer than 20 senior citizen respondents. The results of this questionnaire were tabulated and appear in section II of this report. The questionnaire itself is reprinted in its entirety in appendix C of this report.

Recruited postal inspectors to assist the subcommittee staff as detailees in identifying fraudulent practices in the sale of insurance to supplement Medicare.

Asked every congressional office to save complaints received with respect to the operation of Medicare and private insurance for the month of July 1984. Literally hundreds of complaints were received from a quarter of all congressional offices. The complaints were analyzed and summarized in part and appear in section II of this report.

In order to determine firsthand if abuses in the sale of Medigap insurance policies are as frequent and widespread as this report suggests, the subcommittee staff interviewed a dozen insurance agents in Maryland, Virginia, and the District of Columbia. A senior citizen recruited by the subcommittee to serve as an interested insurance consumer was present at every sales presentation. In addition, a senior citizen recruited for the 1978 investigation was once again assigned to assist the subcommittee. The sales presentations were meant to test whether agents would engage in abusive sales techniques to make a sale. The senior citizen volunteers already had supplemental insurance. One was adequately insured, the other was overinsured. The results of the subcommittee's investigation are detailed in section IV of this report.

Discussed Medigap insurance abuses with participants in senior citizen centers in Maryland, Virginia, the District of Columbia, and Louisiana to ascertain their familiarity with their insurance coverage and its gaps. Our analysis of their perceptions is detailed in section II of this report.

Requested expert analysis of insurance advertisements and literature received by the subcommittee during the course of its inquiry. Solicitations were reviewed by experts with nationally recognized medical or scientific expertise in the specific line of insurance the ad was said to address.

Called upon the General Accounting Office (GAO) to undertake a review of all Medicare supplemental insurance policies promoted to cover the gaps in long-term care. This inquiry is a recent request and currently in progress. Therefore the results are not available for public distribution.

In 1978, the committee found that $1 out of every $4 spent on supplemental health insurance by the elderly was wasted—for a total of $1 billion. The subcommittee estimates that senior citizens will be taken for more than $3 billion in 1986, and that the amount of dollars lost will continue to escalate until corrective action is adopted.

Section 1 of this report documents the dramatic increase in the cost of health care since the enactment of the Medicare Program. In 1950, Americans spent $12 billion for health care. By the end of

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1986, our Nation's annual expenditures for health will have increased a startling 3,535 percent to $424 billion, or an average of $1,723 per person. Expenditures for health care are expected to continue to grow rapidly, more than doubling by the year 2000 to over a staggering $1 trillion.

Increased health care costs impact disproportionately on older Americans who continue to be sick three times as often and three times as long as their under-65 counterparts. The elderly will pay nearly three times as much as younger adults for health care. In 1966, the year that Medicare went into effect, older Americans paid an average of $445 per capita for health care. In 1986, per capita expenditures for health care among the aged will average $4,601. In sum, elderly will pay one-third of the Nation's health care bill in 1986 totaling $131 billion.

The Medicare Program has been a godsend to our nation's 28 million elderly. Today, the program pays about 48 percent of the average older American's health costs. But in order to offset the ever escalating portion of the health bill not covered by the Medicare Program, seniors are increasingly purchasing private health insurance to supplement their Medicare coverage. Today, four of five senior citizens have insurance to supplement Medicare, often referred to as Medigap insurance. (About 10 percent of these senior citizens receive supplementation through the Medicaid Program.) Most have at least one such policy, many have more. This represents a 6-percent increase over 1978—the year the House Select Committee on Aging determined that about two-thirds of the elderly were in possession of Medigap policies. In all, the 21 million elderly who in 1986 own Medigap policies will pay an estimated cost of $13 billion, or more than $600 per person on the average. In return, private insurance will pay about 7 percent of the aged's health care bill, in contrast to Americans under the age of 65 who will pay about $112.4 billion for private health insurance and have approximately 86 percent of their health care bills paid for by private insurance.

In 1972, Blue Cross and Blue Shield provided 50.1 percent of all Medicare supplemental policies; independent plans accounted for 4 percent and commercial insurance companies received a 45.9 percent share of the Medigap marketplace. These figures have changed little over the last 13 years. Blue Cross garnered 45 percent of the Medigap market in 1985, followed by commercial insurance companies and other prepaid plans capturing about 55 percent.

As in 1978, the subcommittee found few problems associated with the sale of Medigap insurance by Blue Cross/Blue Shield or other companies selling group insurance to the elderly. The primary problems still relate to the operation of companies who specialize in the sale of Medigap insurance to the elderly on an individual basis.

Section II of the Report discusses the benefits of the Medicare Program, what it covers and what it does not cover. From the beginning of the Medicare Program, there remains a misunderstanding about the extent of Medicare's coverage. Partly, the result of wishful thinking and partly the result of the distribution of misleading publications which trumpeted Medicare's virtues, senior

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citizens have been left with the impression that Medicare offers comprehensive coverage. In the years following Medicare's enactment, millions of senior citizens have had their illusions rudely shattered having been left with sizable bills which Medicare refuses to pay.

Escalating health care costs have resulted in older Americans actually paying more of their incomes for doctors, hospitals, drugs and long-term care than they did before Medicare was enacted in 1965. Other factors fueling increased health costs borne by elders include the implementation of the new prospective payment system for hospitals in 1983, resulting in a reduction in the number of days a senior citizen will stay in a hospital. This coupled with fewer doctors willing to accept what Medicare offers as full payment (7 out of 10 doctors accepted assignment in 1966, as compared to less than 1 out of 3 today), have both left seniors with a larger portion of their hospital and doctor's bills for which Medicare will not reimburse them.

Coupled with the aged's increased share of the health care bill for services covered by Medicare is the financial burden associated with services not covered by the Medicare Program, including out-of-hospital prescription drugs; eyeglasses and eye care; dentures and dental care; hearing aids and hearing care; custodial nursing home care; most food care; immunizations; and home care services, except under increasingly limited circumstances.

Section III notes that seniors, fearful of potential bankruptcy and loss of financial independence associated with a long, drawn out illness, are increasingly turning to the purchase of private insurance to supplement Medicare. Seventy percent have at least one such policy, many have three, four or more, mistakenly thinking that more is better. Section III describes the types of policies sold in supplementation of Medicare and the marketing methods most commonly used by the health insurance industry. The subcommittee found that the potential benefit from Medigap coverage has declined substantially since 1981, due largely to the imposition of the Medicare prospective payment system which has resulted in shorter hospital stays. Under the new system, older Americans are sent home sooner and for the most part Medigap policies stop paying when one leaves the hospital.

The subcommittee also found that the television is competing effectively with the salesmen as a marketing tool in the sale of insurance to older Americans. Well known personalities are extremely effective, the subcommittee discovered, in inducing thousands of seniors to buy the Medigap policy they endorse. Unfortunately, few elderly understand what Medicare or their private insurance covers, and therefore, are quite receptive to plans offered or promoted by well-known and trusted television personalities. The simple fact is that no policy covers all of Medicare's gaps, and few Americans, including the elderly, understand that fact. A 1986 survey by the subcommittee administered by the Area Agency on Aging directors to over 10,000 senior citizens nationwide underscored this sad truth. Nearly 80 percent of all seniors surveyed in 1980 believed that Medicare would pay for nursing home care should they need it—when in fact, 90 percent of nursing home cafe is rendered in custodial facilities which are not covered by Medi-

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care or private insurance for the most part. The 1986 survey results reaffirmed this 1980 finding.

Section IV of the report reaffirms the 1978 committee finding that older Americans are frequently the targets of fraud and abuse in the sale of Medicare supplemental insurance; that such abuses are not isolated but occur nationwide, and that the incidence of abuse has not diminished but persists in spite of regulatory improvements at the State level. Section IV provides a chronology of Federal, State, local, and private efforts relating to abuses in the sale of Medicare supplemental insurance to the elderly; an analysis of responses from State commissioners of insurance confirming abuses in the sale of Medicare supplemental insurance to the elderly from 1978 to 1986; and a summary of investigations of the House Select Committee on Aging and its Subcommittee on Health and Long-Term Care confirming abuses in the sale of Medicare supplemental insurance to the elderly from 1978 to present day.

Who is responsible for regulating the health insurance industry and what has been done about curbing the increasing incidence of abuse in the sale of such insurance to the elderly? In part, the answer is that the States still retain near-exclusive authority to regulate the insurance industry since the Congress enacted the McCarran-Ferguson Act in 1945, stating essentially that no act of Congress, unless specifically relating to the business of insurance, shall be construed to invalidate, impair, or supercede any State laws regulating the business of insurance.

If the primary responsibility for regulating the sale of insurance rests with the States, the logical question section V of the report seeks to answer is, "How effective have the States been in their regulation of health insurance and more specifically of Medicare supplemental policies?" To determine the effectiveness of the States in monitoring abuses in the sale of Medigap insurance to the elderly, comprehensive questionnaires were prepared and sent by the subcommittee to all 50 State departments of insurance in 1984, and again in 1986. The questionnaire sought answers to questions regarding the State's budget and staff resources for insurance regulation, the dollar volume for all premiums paid for all kinds of insurance sold in their States, State laws in place to protect the public from misrepresentations in the sale of insurance, the number of agents licensed to sell insurance in each State, agent licensing requirements, disciplinary actions taken against agents and/or companies when it was determined that abuse did in fact occur, health insurance complaints received annually, the types of abuses brought to the attention of each State department of insurance, and their views on further regulatory reform necessary or desirable. The responses to these questionnaires were tabulated, analyzed and presented in section V of the report.

Section VI seeks to determine the effectiveness of those Federal agencies with regulatory authority relating to the sale of health insurance in the United States. This section reports on the activities and regulatory authority of the U.S. Postal Service, the Federal Trade Commission, the Department of Health and Human Services and the Justice Department in this regard.

Section VII provides the summary and conclusions of the subcommittee's investigation into abuses in the sale of health insur-

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ance supplementing Medicare, and section VII provides policy recommendations that might be considered by State and Federal lawmakers.

## I. THE NUMBERS

In 1950, Americans spent $12 billion for health care. By the end of 1986, our Nation's annual expenditures for health will have increased a startling 3,535 percent to $424.2 billion, or an average of $1,723 per person. Expenditures for health care are expected to continue to grow rapidly, more than doubling by the year 2000 to over a staggering $1 trillion.

It should come as no surprise to most Americans that health is the second largest and fastest growing industry in the United States today, accounting for about 11 percent of the gross national product.

Table 1 below shows subcommittee estimates of health care expenditures in 1986. Some $157.9 billion or 41 percent of the total was paid for hospital care, including both inpatient and outpatient care. The increased cost of hospital care has a significant impact on our Nation's elderly. Those persons aged 65 and over are two and a half times more likely to be hospitalized than persons under the age of 65, and their average length of stay is nearly twice that of other age groups.

The second largest category of health care expenditures is physicians' services, totalling $75.4 billion or 19.5 percent of the health care dollar. This catchall grouping includes the cost of all services and supplies provided in physicians' offices, expenditures for services by private practitioners in hospitals and other institutions, and diagnostic laboratory work in independent clinical laboratories ordered by physicians.

Dental services account for another 6.5 percent of total health spending. The estimated 1986 dollar amount for these expenditures will total $25.1 billion. Payments for drugs and medical sundries will total some $25.8, accounting for approximately 6.7 percent of the health dollar. An additional $35 billion or 8.3 percent of the 1986 budget will go toward payments for nursing home care.

As the percentages given below in table 1 illustrate, two-fifths of the health spending in 1986 was for health care services provided by hospitals:

TABLE 1.—1986 NATIONAL HEALTH CARE EXPENDITURES

[Dollar amounts in billions]

| | Amount | Percent |
|---|---|---|
| Total | $424.2 | 100 |
| Health services and supplies | 406.9 | |
| Personal health care | 374.3 | 88.2 |
| Hospital care | 172.9 | 40.8 |
| Physicians' services | 82.5 | 19.5 |
| Nursing home care | 35.0 | 8.3 |
| Drugs and medical sundries | 28.3 | 6.7 |
| Dentists' services | 27.5 | 6.5 |
| Other health services | 10.3 | 2.4 |
| Other professional services | 9.6 | 2.3 |

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TABLE 1.—1986 NATIONAL HEALTH CARE EXPENDITURES—Continued

[Dollar amounts in billions]

| | Amount | Percent |
|---|---|---|
| Eyeglass and appliances | 7.4 | 1.9 |
| Program administration | 20.9 | |
| Government public health acts | 11.7 | |
| Research and construction of medical facilities | 17.3 | |

Health care costs have a disproportionate impact on older Americans. During the intervening years from 1950 to the present, the Nation's elderly have continued to be sick three times as often and three times as long as their under-65 counterparts. The elderly also continue to pay nearly three times as much as younger adults for health care. In 1966, the year that Medicare went into effect, older Americans paid an average of $445 per capita for health care. Over the following two decades the elderly's health care costs have taken a quantum leap of some 1,100 percent. According to subcommittee estimates, in 1986, per capita expenditures for health care among the aged will average $4,601.

As detailed in table II below, older Americans' health care costs represent nearly one third of national expenditures in this area. According to subcommittee estimates, the elderly health care bill will total $131.3 billion in 1986, 30.3 percent of the national total of 424.2 billion. The largest percentage of elderly health care dollars goes for the payment of hospital care, with some $59.3 billion paid for such care in 1986. Nursing home care represents the second and fastest growing segment of the elderly's health care expenditures, reaching over $27 billion in 1986. The third largest category of elderly health care expenditures is physician services. The $27 billion spent in 1986 will account for 20.6 percent of the elderly health care budget. Other health services such as home health care and dental and eye care account for $17.5 billion or 13.3 percent of 1986 expenditures.

TABLE II.—1986 ELDERLY HEALTH CARE EXPENDITURES

[Dollar amounts in billions]

| | Amount | Percent |
|---|---|---|
| Personal health care | 131.3 | 100 |
| Hospital care | 59.3 | 45.2 |
| Nursing home care | 27.5 | 20.9 |
| Physician's services | 27.0 | 20.6 |
| Other health services | 17.5 | 13.3 |

The Medicare Program has helped seniors carry some of their heavy health care burden. Expenditures under this program for elderly health care will total an estimated $64.1 billion in 1986, covering 48 percent of older Americans' health costs. Seniors, however, are left with more than half of an ever increasing medical bill. The subcommittee estimates that in 1986 Americans will be forced to

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spend an average of $1,700 out of their own pockets for the health care they require.

In order to offset the ever escalating cost of health care, senior citizens are increasingly purchasing private health insurance policies to supplement their Medicare coverage. Four of five seniors have at least one such policy, often referred to as Medigap coverage.[1] It is not uncommon for older Americans to purchase more than one such policy. In fact, a great many senior citizens are paying monthly premiums for as many as four or five policies; in some instances, they have purchased as many as 30 different policies in a desperate attempt to offset the bankrupting effect of a catastrophic illness.

In 1976, there were 17.1 million Medicare supplemental insurance policies in force, according to the Social Security Administration. By 1985, an estimated 28 million such policies were sold to the elderly and held by them.

Some 11 million older Americans paid an estimated $500 million for private supplemental health insurance in 1972. Today 21 million elderly own such policies at an annual estimated cost of $13 billion, more than $600 per person. They will receive an estimated $7.8 billion in benefits (60 percent of premiums paid), accounting for about 7 percent of their health care bill. The rebate to older Americans after purchase of health insurance bears a sharp contrast to that of Americans of all ages. All told, there are about 217 million Americans with some form of health insurance, or 86.6 percent of the population. They paid about $112.4 billion in premiums in 1983 and they received $96.6 billion or 86 percent of that back in benefits.

In 1972, Blue Cross and Blue Shield provided 50.1 percent of all Medicare supplemental policies; independent plans accounted for 4 percent and commercial insurance companies received a 45.9 share. The 45.9 percent represents a share of commercial insurance sales to the elderly and a 35-percent share representing policies sold to individual senior citizens. These figures changed very little over the past 12 years. Blue Cross/Blue Shield now garners 45 percent of the total. Commercial insurance companies and other prepaid plans receive 55 percent.

The subcommittee staff found few problems associated with the sale of Medicare supplemental insurance by Blue Cross/Blue Shield, by independent plans, or in the practices of commercial insurers who sell group insurance to the elderly. The primary problems related to the operation of companies which specialized in selling Medigap insurance to individuals. Moreover, as the staff soon discovered, the root or the problem lies with the limited coverage that Medicare provides and in the inability of many older Americans to understand what Medicare covers. Section II provides background on the Medicare Program necessary to understanding abuses in the sale of Medicare supplemental insurance.

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[1] Ten percent of those seniors receive supplementation through Medicaid.

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## II. MEDICARE AND ITS "GAPS"

The original mission of the Medicare Program when enacted by Congress in 1965, was a laudable one: to provide a coordinated approach for health insurance and medical care for the aged by establishing:

One: A basic plan providing protection against the costs of hospital and related care financed through a separate Federal payroll tax and a separate trust fund. This is the so-called part A of Medicare that will be referred to hereafter.

Two: A voluntary supplementary plan providing payments for physicians' services and other medical and health services financed through small monthly premiums by individual participants. This part became known as part B of Medicare which is further described below. In addition to premiums, part B is also financed by general revenues from the Federal Treasury.

While this is still Medicare's mission, the cost of the program has risen rapidly over the past 20 years; the cost of hospital and medical care has risen dramatically, and the elderly are paying more for their medical care today than they were before Medicare was enacted, without realizing an increase in the health services provided.

The spiralling cost of this increasingly nonprotective program and its impact on the Federal and aged person's budget has become a subject of increasing concern, and has far-reaching implications. It affects not only the present and future program beneficiaries, and the program itself, but potentially the entire Nation.

This section provides a basic description of the Medicare program. It outlines the growth and development of that program since its enactment in 1965. It also mentions briefly the Medicaid program which offers medical assistance to the poor. It identifies complaints and fears older Americans have with respect to the protection these programs offer, and discusses the forms of protection that have been devised and the forms of protection the elderly seek to curb their dissatisfaction and alleviate their fears concerning their anticipated health care needs.

### MEDICARE—PART A

As noted above, part A is a basic plan to provide protection against the cost of hospital and related care. It is funded through a separate payroll tax and a separate trust fund. Some 98 percent of America's senior citizens are automatically eligible for this protection. In addition, a small number of individuals under age 65 who are disabled or who need kidney transplantation or dialysis are eligible. In fiscal year 1986, an estimated 31 million persons are covered under part A, the so-called hospital insurance portion of Medicare. The 2 percent of the Nation's elderly who are excluded are generally individuals who work in military or Government service who have a separate retirement system and thus have not paid the Medicare payroll tax or to social security in their working years. They may enroll in part A by paying the full actuarial cost of such coverage ($214 a month in 1986).

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From 1967 to 1985 anywhere between 19 and 23 percent of the enrollees under Medicare part A have utilized hospital services each year.

Coverage under part A is based on the concept of a benefit period or spell of illness, a period which begins when an individual enters the hospital and ends when that individual has been out of the hospital or skilled nursing facility for 60 consecutive days. In each benefit period, individuals are entitled to 90 days of hospital care, home health visits, hospice care and, following a hospital stay, up to 100 days in a skilled nursing facility. If hospital benefits are exhausted in a spell of illness, Medicare allows the beneficiary to draw on an additional 60 lifetime reserve days.

As indicated in table III below, although part A is principally financed through a special hospital insurance payroll tax levied on employers, employees, and the self-employed and requires no premium payment, beneficiaries are liable for sharing in the cost of the health services they receive by meeting certain deductibles and coinsurance payments:

For the 1st through the 60th day of a hospital stay, Medicare pays for all covered services except for a first day deductible of $492.

From days 61 to 90 of a hospital stay part A pays for all covered services except for $123 a day. This is called the part A coinsurance.

Each of the 60 lifetime reserve days of the part A benefit is subject to a daily coinsurance of $246.

Part A of Medicare pays for all covered services received by a beneficiary in a skilled nursing facility for the first 20 days. The beneficiary is faced with a daily copayment of $61.50 for days 21 to 100 of such posthospital stay.

Beneficiaries are also fully liable for a deductible for the costs, or the replacement of the first three pints of blood.

Coinsurance and deductibles as outlined above are important concepts to remember, because these costs are generally all that is covered by most Medicare supplemental insurance policies.

TABLE III.—MEDICARE BENEFITS

Part A: Hospital Insurance Benefits

| Coverage per "benefit period" | Beneficiary payments |
|---|---|
| A. Inpatient hospital service: | |
| First 60 days | $492. |
| 61st to 90th days | $123/day. |
| 60 lifetime reserve days | $246/day. |
| B. Skilled nursing facility services: | |
| First 20 days | None. |
| 21st to 100th days | $61.50/day. |
| C. Home health care: Unlimited visits | None. |
| D. Hospice care: Have to be declared terminally ill | 5 percent inpatient costs up to $492. |
| E. Blood | 1st 3 pints. |

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MEDICARE—PART B

The Supplemental Medical Insurance Program (part B) is a voluntary program which provides older persons with protection against the costs of physicians' services, home health services, and numerous other medical and health services in and out of medical institutions. All persons age 65 and older who are eligible for Social Security benefits may elect to enroll in part B. An overwhelming majority, 97 percent, of Medicare part A beneficiaries maintain coverage under part B.

Those beneficiaries who elect to participate in Medicare part B must pay a monthly premium, equal to 25 percent of the program's costs, currently set at $15.50, or $186 a year. In addition, seniors must pay a deductible of $75. In other words, the elderly must pay the first $75 of their doctor's bill before Medicare will begin to help pay. Once the deductible is met, Medicare will pay 80 percent of what it determines are reasonable charges.

Part B of Medicare pays for 80 percent of reasonable charges for the following covered services: doctor's fees in or out of the hospital, home health visits (not subject to coinsurance), medical and related services, outpatient hospital services, and laboratory services. Radiology and pathology services provided by physicians to hospital inpatients are reimbursed without regard to the coinsurance and deductible requirements. If all of this is not complicated enough, payments for physicians' services are based on two other factors which go into the determination of what Medicare considers the reasonable charge. These factors are the customary charge and the prevailing charge.

The customary charge is the physician's median charge for a specific service or procedure in the previous year. For example, if your doctor has been charging patients from $1 to $30 for an office visit, his/her median or customary charge would be something around $15. One obvious point is that the use of this factor creates a disincentive for doctors to lower rates. In cutting fees the physician lowers his/her median charge and hence reduces what Medicare is likely to pay him/her in the following year.

The prevailing charge is the 75th percentile of what all doctors in a specified area charge for a specific service or procedure. For example, if doctors in Chicago are evenly distributed in charging from $1 to $30 for an office visit, the 75th percentile would be $22.50. This would be the Medicare prevailing rate.

Reasonable charge is defined by Medicare as the lowest between the following: (a) What the doctor charges the individual; (b) the doctor's customary charge; and (c) the prevailing charge in that area.

TABLE IV.—MEDICARE BENEFITS

Part B: Medical Insurance Benefits

| Coverage per "benefit period" | Beneficiary payments |
|---|---|
| A. Doctors services: services provided by: | |
| Doctors of medicine and osteopathy | (1) $75 annual deductible. |

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TABLE IV.—MEDICARE BENEFITS—Continued

| Coverage per "benefit period" | Beneficiary payments |
|---|---|
| Dentists performing dental surgery | (2) Coinsurance of 20 percent of reasonable charge. |
| Podiatrists (excluding normal foot care) | |
| Chiropractors for treatment involving manual manipulatin of the spine to correct a subluxation | (3) Any amount in excess of reasonable charge. |
| Optometrists for treatment of asphyxia | |
| B. Other medical and health services: | |
| Diagnostic x ray and lab tests | |
| Outpatient hospital and surgical services | |
| X ray and other radiation therapy | |
| Outpatient mental health services | |
| Services and supplies furnished in connection with physician services | |
| Surgical dressings, splints, and casts | |
| Durable medical equipment | |
| Artificial devices that replace all or part of an internal body organ | |
| Ambulance services | |
| Braces and artificial legs, arms, and eyes | |
| Physical and speech therapy | |
| Rural health clinic services | |

As stated above, Medicare part B pays 80 percent of reasonable charges. However, less than one third of all doctors providing Medicare services, accept assignment and agree to bill the Government directly for services they provide accepting as full payment what Medicare determines as reasonable charges. The rest, about 70 percent of Medicare doctors bill beneficiaries for more than the Medicare reasonable rate. As table V indicates, the assignment rate, the percentage of doctors accepting Medicare assignment, varies by medical specialty, from a high of 46.2 percent of nephrologists to a low of 23.6 percent among general practitioners (GP's). In the June 9, 1986 issue of Medical Economics, it was reported that:

The portion of physicians who agreed to accept Medicare reimbursement as payment in full dropped from 30.4 percent in fiscal 1985 to 28.4 percent this year—largely because of attempts to extend the (physician) fee freeze, HCFA says.

TABLE V.—PERCENT OF PHYSICIANS WHO ACCEPT ASSIGNMENT

| | Percent | | Percent |
|---|---|---|---|
| Nephrologists | 46.2 | Neurologists | 33.2 |
| Radiologists | 39.5 | Internists | 31.1 |
| Cardiologists | 38.8 | OBG's | 30.5 |
| Orthopedic surgeons | 38.3 | Urologists | 29.0 |
| Dermatologists | 37.8 | Psychiatrist | 27.8 |
| Pathologists | 37.7 | Family practitioners | 27.1 |
| General surgeons | 34.5 | Otolaryngologists | 25.1 |
| | | General practitioners | 23.6 |

*A. Medicare 1986: Increasing costs of services covered by Medicare*

Outlays for elderly health care benefits by the Medicare and Medicaid Programs amounted to $78 billion in 1985, or 23 percent of the $341 billion spent for personal health care. The Govern-

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ment's share of the health care expenditures for the elderly has increased as a result of Medicare and Medicaid from 30 percent in 1966 to 62 percent of the total this year. But once again, the statistics may be misleading. The Medicaid Program—a Federal/State grant-in-aid welfare program, which is available to the poor of all ages—has increased dramatically while Medicare's share of the elderly's total health care bill has decreased.

In 1967, the first full year of Medicare, the plan covered 46 percent of the elderly's medical bills. By 1969, it paid almost 50 percent. Today, Medicare pays for only 48 percent of the average senior citizen's health care bills.

As illustrated in table VI, elderly Americans are actually paying more of their incomes for doctors, hospitals, drugs and long-term care than they did before Medicare was enacted in 1965. The subcommittee estimates that the average older American will spend 17 percent of his/her income on health care, up two percentage points of the pre-Medicare rate of 15 percent. According to subcommittee estimates, the average out-of-pocket health bill for seniors will top $1,700 in 1986, an increase of nearly 1,500 percent from the comparable 1966 figure of $110. Table VI also illustrates the failure of Medicare to provide protection for older Americans against the skyrocketing costs of health care in terms of total income. In 1966, before the full enactment of Medicare, seniors were spending 15 percent of their income on health care. Twenty years after the enactment of Medicare, the average older American has to spend more—some 17 percent or 2½ months of his/her income—on health care.

As table VII below illustrates, Medicare is paying a significant percentage (69 percent) of the elderly's hospital costs and a little more than half (59 percent) of their doctor bills. This program pays a negligible portion of the total bill for nursing home care (2 percent) and even less for prescription and over-the-counter drugs used by older Americans. The senior must then fill out the Medicare forms and seek repayment from Medicare for the 80 percent of the Medicare rate, leaving them fully responsible for the remaining 20 percent of the Medicare rate and 100 percent of their doctor's charge above that amount. For example, if a doctor who does not accept assignment, charges a Medicare beneficiary $100 for an office visit and Medicare determines the reasonable charge to be $50, Medicare will reimburse the beneficiary for only $40 (80 percent of $50) and the beneficiary would have to pay the remaining $60 of the bill out of his or her own pockets.

The natural question that arises is: Why are older Americans paying more and more for less and less protection from Medicare? The answer has many parts.

First, the elderly's share of costs for Medicare covered services has risen dramatically over the past 20 years. Medicare deductibles, coinsurance and premiums have skyrocketed since 1966, leaving seniors with higher and higher out-of-pocket costs. What follows is a summary of these cost sharing changes. Frighteningly, they are projected to continue to increase at a dramatic pace.

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TABLE VI

Elderly Out-of-Pocket Health Care Costs:
The Impact of Medicare

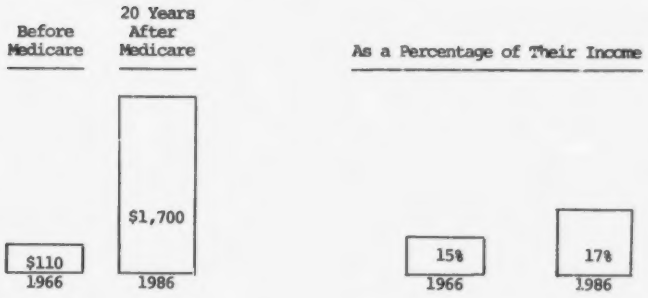
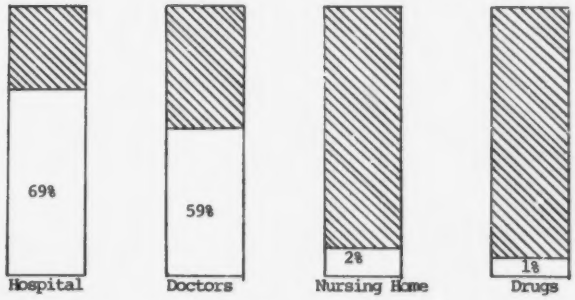



TABLE VII

What Medicare Pays: Percentage of Elderly Health Care Costs Covered By Medicare

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Since the enactment of Medicare in 1966, the dollar amount for the part A hospital deductible has risen from $40 to $492. By 1991 it is predicted to reach $732.

| Year: | Rate |
|---|---|
| 1966 | $40 |
| 1967 | 40 |
| 1968 | 40 |
| 1969 | 44 |
| 1970 | 52 |
| 1971 | 60 |
| 1972 | 68 |
| 1973 | 72 |
| 1974 | 84 |
| 1975 | 92 |
| 1976 | 104 |
| 1977 | 124 |
| 1978 | 144 |
| 1979 | 160 |
| 1980 | 180 |
| 1981 | 204 |
| 1982 | 260 |
| 1983 | 304 |
| 1984 | 356 |
| 1985 | 400 |
| 1986 | 492 |
| 1987[1] | 572 |
| 1988[1] | 616 |
| 1989[1] | 648 |
| 1990[1] | 688 |
| 1991[1] | 732 |

[1] HCFA projections.

The hospital deductible is calculated on the basis of the average costs of hospital care provided Medicare patients per day. Because of this, since the 1984 imposition of the Medicare prospective payment system, the deductible has grown at a startling rate. Under the new payment system, Medicare pays hospitals a fixed amount per case based on the diagnosis of the patient treated. Unlike the old cost-based reimbursement system, the new payment method provides hospital strong incentives to get people out of hospital sooner. As a result, the average length of hospital stays paid for by Medicare has dropped from 9.5 in 1983 to 7.5 today. While overall Medicare hospital costs per stay have decreased slightly under this system, the average costs per day of care have risen sharply. The result of this has been an increase in part A hospital deductible from $304 in 1983 to $492 today. Further leaps in the deductible are predicted. By 1991, it is expected to reach a whopping $732!

The part A coinsurance rates for long hospital and skilled nursing facility stays are calculated based on the above detailed part A deductible. Accordingly, these rates have jumped dramatically over the past 20 years as well. The hospital coinsurance for days 61 to 90 in a hospital has risen from $10 to $123. The coinsurance for the 60 additional lifetime reserve hospital days has risen from $20 to $246. The coinsurance for the 21st through 10th day in a skilled nursing facility (SNF) has risen from $5 to $61.50 a day. As shown below, these costs are expected to nearly double again by 1991.

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| Year | Hospital days 61 to 90 | Hospital reserve | SNF days 21 to 100 |
|---|---|---|---|
| 1966 | $10 | $20 | $5.00 |
| 1967 | 10 | 20 | 5.00 |
| 1968 | 10 | 20 | 5.00 |
| 1969 | 11 | 22 | 5.50 |
| 1970 | 13 | 26 | 6.50 |
| 1971 | 15 | 30 | 7.50 |
| 1972 | 17 | 34 | 8.50 |
| 1973 | 18 | 36 | 9.00 |
| 1974 | 21 | 42 | 10.50 |
| 1975 | 23 | 46 | 11.50 |
| 1976 | 26 | 52 | 13.00 |
| 1977 | 31 | 62 | 15.50 |
| 1978 | 36 | 72 | 18.00 |
| 1979 | 40 | 80 | 20.00 |
| 1980 | 45 | 90 | 22.50 |
| 1981 | 51 | 102 | 25.50 |
| 1982 | 65 | 130 | 32.50 |
| 1983 | 76 | 152 | 38.00 |
| 1984 | 89 | 178 | 44.50 |
| 1985 | 100 | 200 | 50.00 |
| 1986 | 123 | 246 | 61.50 |
| 1987[1] | 143 | 286 | 71.50 |
| 1988[1] | 154 | 308 | 77.00 |
| 1989[1] | 162 | 324 | 81.00 |
| 1990[1] | 172 | 344 | 86.00 |
| 1991[1] | 183 | 366 | 91.50 |

[1] HCFA projections.

The premium for medical insurance, Medicare part B, has risen from $3 to $15.50 a month:

| Year | Rate | Year | Rate |
|---|---|---|---|
| 1966 | $3.00 | 1979 | $8.70 |
| 1967 | 3.00 | 1980 | 9.60 |
| 1968 | 3.00 | 1981 | 11.00 |
| 1969 | 4.00 | 1982 | 12.20 |
| 1970 | 4.00 | 1983 | 12.20 |
| 1971 | 5.30 | 1984 | 14.60 |
| 1972 | 5.60 | 1985 | 15.50 |
| 1973 | 5.80 | 1986 | 15.50 |
| 1974 | 6.30 | [1]1987 | 17.80 |
| 1975 | 6.70 | [1]1988 | 18.50 |
| 1976 | 6.70 | [1]1989 | 19.30 |
| 1977 | 7.70 | [1]1990 | 20.00 |
| 1978 | 8.20 | [1]1991 | 20.70 |

[1] HCFA projections.

As indicated by the charts above, the hospital deductibles and coinsurance have increased over 1,200 percent since the inception of Medicare. The part B monthly premium for physicians's service has jumped 517 percent.

Second, central to any discussion of the older person's increased health care bill is physican fees. In 1984, Medicare paid for only 58 percent of physican fees, which account for 21 percent of the elderly's total health care expenses. The decline in Medicare's share of expenses for physician services has resulted partly from the increase in the deductible for part B from $50 to $60 to $75 in 1983. More importantly, however, is the fact that many doctors now

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choose not to accept the Medicare reasonable rate and that the difference between this rate and what is actually billed by these nonparticipating doctors is increasingly steadily, saddling the elderly with larger and larger out-of-pocket costs.

Congress has frozen Medicare reimbursement for doctor services since 1984 and long delays (often as long as 4 to 6 months) in the processing of claims by the Medicare carriers have gotten worse in recent months because of administration attempts to save money by slowing down paying the Government's bills. Congress has tried to provide incentives for Medicare assignment by promising quicker claims processing and full payment increases to those doctors who agree to accept assignment for all their Medicare claims. While this has resulted in a slight improvement in the national assignment rate, much of these efforts have been counteracted by failure to speed up claims processing and increasing costs of medical practice.

The more than two-thirds of physicians not accepting Medicare assignment have steadily increased their bills, outpacing increases in Medicare reasonable charges, and leaving the elderly to foot a larger and larger portion of their doctor bills. In 1975, the average difference between the Medicare reasonable charge and the amount billed patients by physican not accepting Medicare assignment as 16.7 percent. In other words, an average physican not accepting assignment would have billed $116.70 for a procedure or service Medicare would have determined to reasonably be worth $100. By 1984 the average discrepency between bills and Medicare rates had increased to 23.6 percent, meaning that Medicare is actually paying for no more than 65 percent of nonassigned doctor bills. For example, take a bill for $124 from a doctor not accepting assignment. If this was an average bill in 1984, Medicare would have deemed the reasonable charge to be $100 and pay $80 (80 percent), leaving the beneficairy to pay $44 of the $124, fully 35 percent of the total bill. If the doctor in this example did accept Medicare assignment, the beneficiary would have had to pay $20, 20 percent of the Medicare reasonable charge.

A third factor adding to the health costs of, and eroding the quality of care provided to, the elderly has been the increasing number of retroactive payment denials by the Health Care Financing Administration, the Federal agency charged with administering Medicare. The subcommittee held a hearing in Jefferson City, MO in March of 1985 to examine the nature and extent of such denials. It was learned that many seniors are having vitally needed care refused, sometimes saddling them with huge medical bills, sometimes resulting in pain, suffering and even death. Dr. David Voshall told the subcommitte of one such case:

> J.K. was an elderly white male who presented himself in the (doctor's) office. He was known to have coronary artery disease. He had recently been hospitalized for epigastric pain and found to have gall bladder disease. When he came to the office on October 4, 1984, he was complaining of nausea, abdominal pain, and chest pain * * * His admission (to the hospital) was denied. I recommended that

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J.K. go into the hospital. He refused. The next morning he died at home of cardiac arrest.

It was also revealed at this hearing that many of the Peer Review Organizations (PRO's), the independent physician group employed by Medicare to review the care provided in hospitals to Medicare patients, had stipulated in their contracts the objective of reducing hospital admissions by significant amounts. In the case of Missouri, the PRO's contract called for a statewide reduction of 65,328 hospital admissions, a cut of some 10 percent of the total. These reductions have several impacts. First, they may indeed eliminate some unnecessary services being provided to Medicare beneficiaries. Second, if improperly made, they may deny access to needed care such as in the example above. This may happen either by a denial by the PRO or a denial of admission to the hospital, which, based upon past denials, fears that it may not be paid by Medicare if the patient is admitted.

Retroactive denials of payment for Medicare-covered services have not been limited to hospital care. The subcommittee has received hundreds of letters and phone calls from across the nation detailing technical denials of care and payment for care by Medicare and the officials which administer it. In what Medicare officials call "tightening" of controls on the use of skilled nursing facilities and home health care, millions of older Americans are denied the care they desperately need. This comes at a time when demand for these services is skyrocketing because of the proclivity of hospitals to discharge hospital patients sooner and sicker under the new Medicare prospective payment system. The following section contains a number of glaring examples of these benefit cutbacks.

The common denominator of all these factors is cost. The cost of hospital care has increased dramatically, as has the cost of physician care. As noted, the increases in the cost of health care have outpaced increases in the cost of living and elderly income by a wide margin. As costs have risen, the levels of coinsurance amounts and deductibles have also increased. Since these increasing costs have already placed a considerable strain on the Medicare Trust Fund, Congress has been reluctant to increase benefits. Congress has had to fight off continuous attempts by this administration to increase costs borne by the elderly and to decrease services.

To the elderly, all of this means that they are on a kind of health care merry-go-round which never stops—instead it gradually picks up speed every year. In addition to having to pay more to participate in Medicare and finding Medicare will pay less and less of their health bills, the elderly have been confronted with escalating costs of health care services which they vitally need but for which Medicare does not provide coverage.

*B. Increasing costs and the increasing need of services not covered by Medicare*

Coupled with older Americans' increased share of the health care bill for the services covered by Medicare is the financial burden associated with necessary health services often not covered by the program.

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Medicare explicitly excludes from coverage an array of important services used by the elderly. These include:

*Drugs which can be self administered.*—People over 65 represent 12 percent of the population, yet they take about 30 percent of prescription drugs. On the average, seniors use some 13 prescriptions per person per year. Seventy percent of the elderly use over-the-counter drugs, compared to about 10 percent of the general adult population. Although drugs and sundries are needed by such a large number of older citizens, Medicare pays nothing. Medicaid pays about 6 percent (for impoverished elderly), but pays nothing for over-the-counter drugs. The bulk of the elderly's annual drug bill—some $10 billion annually—must be paid out of their own meager incomes. Payments for drugs represent up to 20 percent of the elderly's total out-of-pocket health care costs—$340 per person per year.

*Dental care.*—Dental problems such as tooth decay and periodontal disease are so widespread among the elderly that half of all persons over 65 have no natural teeth; almost 1 in 10 of those elderly persons without natural teeth also have no dentures. Medicare pays for no dental care except very selective forms of dental surgery. It does not pay for regular dental care or dentures. As of 1983, Medicaid programs in 44 States offered dental services and 37 provided some coverage for dentures. Dental services account for about 2 percent of the elderly's health care expenses.

*Eyeglasses or eye examinations.*—Nine out of ten, or 26 million older Americans require and own eyeglasses. However, 1 in 5, or over 5 million of these seniors are wearing glasses which need replacement or correction. Medicare pays nothing of the costs of eyeglasses or related care. It does not pay for routine tests which may prevent more serious vision problems. In 1983, 46 State Medicare programs offered coverage of eyeglasses for indigent residents.

*Hearing care or examinations.*—One in three persons over age 65 suffers from impaired hearing. For 8 percent of the elderly, the problem is so severe that they are unable to hear words spoken in a normal voice. An estimated 10 percent, or 2.8 million elderly use hearings aids which cost from $200 to $1,000. Medicare does not pay for hearing aids or routine hearing care.

*Custodial nursing home care.*—Nursing home care is the second largest and fastest growing personal health care expenditure by older Americans, amounting to $32 billion, or nearly $1,200 per capita in 1986. Expenditures for the 5 percent of the elderly in nursing homes are obviously much higher, from $20,000 to $40,000 a year. Medicare pays virtually nothing—just a little more than 1 percent of the costs for those 1.4 million elderly Americans confined to nursing homes. The reason for that is that Medicare does not pay for custodial care for the elderly in their own homes or in nursing homes. Medicare will only help to cover the costs of skilled nursing care after a hospital stay of 3 days. In addition, the skilled nursing facility care must be prescribed by a doctor, be required for care for a condition which was treated in the hospital, and be

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approved by the facility's utilization review committee or a peer review organization. The vast majority of nursing home care required by older Americans is for a number of chronic, long-term impairments and does not meet the Medicare definition of skilled care. Therefore, those in need are required to carry the tremendous costs of such care on their own. Half of nursing home admissions are attributable to Alzheimer's disease, the dastardly, degenerative organic brain disease which robs up to 4 million Americans of mind and ultimately body. Medicare pays nothing for the care and treatment of Alzheimer's disease victims. As a result of the absence of any assistance from Medicare for this expensive care, most seniors are quickly impoverished after entering a nursing home. It is only after one has spent all of his or her money and sold most assets that he or she may get any government assistance—from Medicaid, the Federal/State welfare program. Medicaid pays for approximately 45 percent of nursing home costs.

*Home health care.*—Home health care services are covered by Medicare only when a very limiting set of criteria are met. To receive home health care, a Medicare beneficiary must demonstrate he or she is homebound, and that the care needed: (1) includes skilled nursing care, physical therapy, or speech therapy; (2) is part time or intermittent; (3) is prescribed in a plan or care by a physician; (4) is provided by a Medicare-certified home health agency. Because of these very restrictive eligibility criteria and Medicare's even more restrictive interpretation of them, an estimated 5 million Americans today go without the home care they need. It is estimated that nearly half of the 1.4 million elderly in nursing homes could be cared for at lower cost and with better quality in their own homes if proper care was available. Thousands more must receive needed care in the hospital when less expensive care could be provided in the home, imperiling their lives and unnecessarily wasting millions of Medicare dollars.

In March of 1986, the second in a series of hearings on catastrophic health insurance was held by the subcommittee in Washington, DC. This hearing focused on "Catastrophic Health Insurance: The Home Care Benefit." A panel of Americans, young and old, gave testimony about their personal problems trying to obtain vitally needed home care.

Ms. Randy Kramer of Miami, FL is a victim of cystic fibrosis whose survival depends on twice daily respiratory therapy to clear her lungs. She told the subcommittee: ". . . I am just one person speaking for the 47 million victims of chronic lung disease. . . . Medicare says that in order to receive home care I must be homebound. Even when I am homebound, Medicare will only pay for a physical therapist or a skilled nurse. This forces me to use the outpatient department of the Baptist Hospital for my treatment. The cost of these treatments is $190 a day. The cost of the same treatment at home is $60 a day. The Government can save a lot of money by letting me have my therapy at home. It would be better for me because every time I go to the hospital I am exposed to sickness that could cause readmission to the hospital. I am burning up my Social Securi-

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ty money on travel (to the hospital) and it is also wear and tear on my body."

The subcommittee's report, "The Attempted Dismantling of the Medicare Home Health Care Benefit," released at this March 19, 1986, hearing, details the actions taken by the Department of Health and Human Services and its fiscal intermediaries cutting the home health benefit. The report contains glaring examples of the denial of needed home health care to Medicare beneficiaries. Included among these cases are the following:

Mr. S. received daily visits for 2 weeks for treatment of open wounds in the groin area. During the third week, (Medicare) disallowed two of five visits despite documentation of continued open areas with purulent drainage. The patient was unable to reach these areas for dressing changes and no one else was available to provide the care. Medicare declared the two visits not reasonable and necessary.

Mrs. P. was a 90-year-old woman with terminal cancer. Her family wanted to keep her at home with the assistance of the home health agency. Mrs. P. suffered from constant diarrhea, resulting in electrolyte imbalance, dehydration, and skin breakdown. Her condition was further complicatd by heart disease. Medication management was a problem for both Mrs. P. and her family. Medicare benefits were denied because (Medicare said) Mrs. P. did not need intermittent care. She died 2 weeks later.

Mr. L. was a 76-year-old in frail condition. He was bedbound with a diagnosis of pneumonia, chronic obstructive pulmonary disease, rib fractures, and flail chest. His doctor stated that daily intermittent positive pressure breathing treatments were needed due to Mr. L.'s severely compromised respiratory system. However, Medicare denied the daily treatments for 2 weeks, deeming them not medically necessary. Mr. L.'s frail and elderly wife could not carry out the treatments alone, however.

Mrs. P., a blind, diabetic double amputee, went to renal dialysis three times weekly. Her husband carried her to the car. She was declared not homebound.

Mrs. K. was confined to a wheelchair because of a stroke. She was unable to care for herself at all. Her elderly husband managed to get Mrs. K. to physical therapy three times a week under the orders of her physician, who thought there was a possibility for some rehabilitation. (Medicare) said that because Mrs. K. went to therapy three times weekly instead of two, she was not homebound. All of her skilled nursing and home health aide visits were denied.

*Routine physical examinations.*—Medicare and Medicaid do not provide coverage for physical checkups which in many cases detect developing disabilities in their early stages. Less than a million Medicare beneficiaries have elected to receive their health care through health maintenance organizations (HMO's). HMO's do offer preventive physician visits as a regular benefit.

*Immunizations;*

*Most foot care;*

*Homemaker services and meals at home; and*

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*Treatment outside the United States.*

This abbreviated list of noncovered services is testimony to the narrow, acute care view Medicare has regarding the care elderly patients need. Unfortunately, Medicare, the program that was supposed to give older people a hedge against the overwhelming cost of health care, denies reimbursement for much of the services elderly people need the most.

*C. Medicare: Beneficiaries' assessments*

The subcommittee recently contacted each Member of Congress requesting that all constituent corespondence received in a recent month outlining difficulties encountered in the Medicare Program be forwarded to the subcommittee for review. Thousands of letters poured in detailing the frustration of growing old without the health care protection anticipated from the Medicare Program.

The testimonials of poor care, denial of care, abuse, deception, confusion and fear which unfold throughout the pages of these letters would open the eyes of even the most myopic to the inadequacies of our present health insurance programs. From elderly across the Nation we have learned that the health services needed the most are not covered by Medicare, and that many elderly are literally forced into poverty to obtain these costly, noncovered services. The letters revealed the tremendous fears older Americans have of not being able to afford the health care they need, as well as their anger at repeated attempts by this administration to cut Medicare benefits and increase their share of the costs. Excerpts from some of these letters follow:

I started on Social Security when it began in 1937 and paid into it ever since. Everyone thought it would give peace of mind when they retired or became too ill to work any more. Now I hear there are proposals to cut down on Social Security and Medicare—thanks a lot. It seems we elect officials to go to Washington to cut our throats. Why is it a man makes promises he never intends to keep?

R.P., *Los Angeles.*

A lot of older people cannot afford medical care, even with Medicare, because they can't pay the extra costs. We cannot, so we go untreated.

E.R., *Pembroke, Pines, FL.*

Why are the payments for Medicare becoming so expensive and the cost of living raise doesn't compensate for the increase? Our Government keeps raising our premiums and then turns around and cuts our benefits twice as much.

*Y.K., Arizona.*

Errors, long delays, indifferent cooperation, and unjustified denials of claims have made the Medicare Part B reimbursement program a horrendous nightmare. Confusion and inefficiency surrounding this process is not ony frustrating, but appears to be almost calculated to discourage our elderly citizens from seeking necessary medical attention. It could be a national scandal; it deserves immediate Congressional investigation. In several instances I have been forced to resubmit claims as often as three times. Enclosed is a copy of the surgeon's bill filed with Medicare Part B in December of last year in the amount of $3,083 for which I have received to date the some of $402.80 after three trips to the doctors' office, plus several phone calls to Medicare.

E.P., *Sarasota, FL.*

Since Medicare pays such a small share of the cost to the physician, why is he allowed to increase his fee and when the Medicare patient must pay more to the doctor to make up for what Medicare does not pay him? $45.00 for an office visit is ridiculous when the doctor spends 5 minutes with you.

I'm afraid some will try to turn Medicare into a welfare type program to cut the patient's hospital care. Please do what you can to stop them.

D.D., *Hampton, VA.*

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It now takes 6 months to get Medicare bills (even those paid in advance) processed and claims for my 93 year old mother. She would never collect if she did not have someone to help her. It's disgusting.

B.C., *Miami, FL.*

The elderly don't want a government freebie. What we want is comprehensive health care at an affordable price.

F.M., *Bronx, NY.*

I'm concerned with the runaway costs. The reason I didn't retire earlier was that I was more concerned with keeping my company's medical plan and not relying on Medicare which I feel will be bankrupt the way its going. I was in the hospital for a total of 4 days. No surgery—just tests. The total cost was over $5,900 and even with two insurances it looks as if I will be stuck for over $1,500 because of deductibles and all.

ANONYMOUS.

My husband is a patient in a nursing home and can get no assistance because of his illness is diagnosed as Alzheimer's disease. Why can't Medicare help in any way. It is very costly and I don't know how much longer we can pay the bills.

M.S., *Atlanta, GA.*

I'm on Medicare. It wouldn't be so expensive it doctors were not given the right to legal robbery by overcharging. My doctor told me, "What do you care what I charge. It's covered by Medicare.

B.M., *New York.*

I am a widow and live on my Social Security check of $391 a month. I simply cannot afford an increase in Medicare. After I pay rent, food, insurance, eye doctor and family doctor, if an emergency comes along I have nothing left.

L.C., *Texas.*

I paid taxes all my life. I was refused entrance into hospital recently because I had no Medi-Cal. I am 73, and I am in need.

ANONYMOUS.

The prescription medication for my wife and I alone amounted to more than $1,000 in 1983, which exceeded 10 percent of our income. Medicare doesn't even consider these bill.

P.M., *Kansas.*

I carry Medicare and Blue Cross/Blue Shield but during last year I paid out of pocket over $10,000 for doctors, hospitals, and nursing home costs.

J.S., *Bradenton, FL.*

I recently lost my husband of 44 years after a long period of severe heart disease. The medical bill after 2 months of intensive care, and many weeks of recuperation after 2 strokes and the drugs are astronomical[1]. Medicare is totally inadequate and we just were never able to save. So after his death I am faced with a devastating problem.

ANONYMOUS, *Vermont.*

Something must be done about the catastrophic cost of long term health care. My 85-year-old husband suffering from Parkinson's disease fell and broke his hip. He had to go to a nursing home. Nobody provides skilled nursing care at home. Medicare and medicaid cut that benefit years ago. He wants to come home. He's very unhappy in the nursing home. In 1 month he lost 16 pounds.

K.S., *Florida.*

My husband has Alzheimer's disease. Since I could no longer take care of him, I've admitted him to a nursing home. Medicare will not pay any of the cost. The financial burden ($20,000 yearly) is tremendous. I don't know where to turn.

N.K.

**The preceding sections indicate that seniors have a well founded concern of Medicare's ability to protect them against skyrocketing health care costs. They are fearful of having to forego care when they need the most because of depleted financial resources. Projections are that Medicare will cover less and less of older American's fast growing health care bill. To many elderly, the bottom line to this is that they must look elsewhere for health protection. There are but two alternatives: Medicaid and private insurance.**

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## MEDICAID

Medicaid is a Federal/State grant in aid program in which the Federal Government pays at least 50 percent of the costs incurred by the States paying for medical assistance to low income residents. Unlike the Medicare Program, Medicaid is not available to all senior citizens—only those who meet very strict income and asset requirements. To be eligible for Medicaid, a welfare program, in most States seniors have to have incomes well below the poverty level and have little to no assets.

Because many elderly have incomes which place them at or near the poverty level many are eligible for Medicaid benefits. In 1985, an estimated 12 percent persons over 65 will receive benefits under the Medicaid Program.

For many seniors, accepting Medicaid's benefits is a last resort. Seniors fear going on welfare. There is a tremendous psychological trauma associated with the acceptance of such moneys and most older Americans avoid it if they can. This trauma is understandable because the elderly must first give up their homes and lifetime savings before they can qualify for Medicaid.

The Medicaid Program provides coverage for inpatient hospital services, physician services, (whether furnished in the office, the patient's home, a hospital, or a nursing home), skilled nursing facility services, intermediate care facility services, skilled home nursing services, and laboratory and x-ray services. Other items or medical services can be provided at the option of the States.

The Medicaid law provides that no deductible, cost-sharing, or similar charge can be imposed by the State for hospitalization under its program and that such a charge on other medical services must be reasonably related to the recipient's income or resources. In addition, the Medicaid Program requires that elderly needy recipients under the State program must be provided assistance to meet the deductibles imposed by Medicare Part A.

The first experience most seniors have with Medicaid is when they need nursing home care. Expenditures for nursing home care are far and away the largest and fastest growing component of the Medicaid budget, accounting for 55 percent of the total budget in 1985. What typically happens is that seniors enter nursing homes paying the bills completely out of their own pockets. As mentioned earlier, Medicare pays for virtually no nursing home care. Seniors soon exhaust all of their own money because the cost of an average nursing home stay is more than $2,000 a month. After turning to family and friends and exhausting any help available there, the elderly, now destitute, are forced to apply for medical assistance through Medicaid.

Most of America's senior citizens, having grown up with the work ethic and priding themselves on their independence and self-sufficiency, will do almost anything rather than end up on the Medicaid roles as a Medicaid patient.

A last alternative is the purchase of private insurance to supplement Medicare.

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## III. FILLING THE "GAPS": MEDICARE SUPPLEMENTAL INSURANCE

Observing that Medicare continues to pay a smaller proportion of their ever escalating health care costs and out of fear of potential bankruptcy and loss of financial independence, more than ever older Americans are turning to the purchase of private supplemental health insurance. At the present time, the subcommittee estimates that up to 80 percent,[2] or an estimated 22.4 million out of America's 28 million citizens age 65 and older, have at least one health insurance policy in supplementation of Medicare. This represents an increase of nearly one-fifth in the percentage of older Americans with such insurance for an increase of some 7.4 million privately insured seniors since the committee issued its landmark study in 1978. Many seniors (an estimated 30 percent) have purchased up to 30 different policies without realizing that Medicare supplemental policies generally include a coordination of benefits clause which means that in areas of overlap only one policy will pay benefits.

Medigap insurance, even to the trained expert, is complex and often confusing. There are many different types of insurance and countless specific variations from policy to policy. It is very difficult for seniors to discern exactly what they are getting when they purchased a Medigap policy. It is very difficult to the consumer to determine the worth of the product reading the insurance policies in question. There is very often little information available to older Americans to assist them in purchasing Medigap. Thus, there is almost no opportunity to comparison shop. For most seniors the purchase of insurance is a reflex action; motivated by fear, they buy hope.

### *A. Types of Medigap policies*

Medigap policies fall into the category of health insurance policies, also known as accident and health or disability policies. The terms are used synonymously in this report. There are four general types of policies which fall under the heading of Medigap:

(1) *Service benefit.*—This is the most common and widely known type of Medigap insurance. Service benefit policies generally provide coverage for a percentage of the Medicare coinsurance and deductibles. (See section II of this report for details on coinsurance and deductibles.) These policies, as their name implies, pay benefits based on the cost of medical services rendered to the beneficiary. Service benefit policies typically provide no protection against the costs of drugs, custodial nursing home care, private duty nursing care, dental care, eye care and hearing care.

Under model State regulatory standards developed in 1981 by the National Association of Insurance Commissioners (now utilized by 46 States), service benefit policies must cover:

The Medicare Part A hospital copayment for days 61–90 of a hospital stay;

The part A copayment for lieftime reserve days of hospital care; and

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[2] Ten percent of these seniors receive supplementation through Medicaid.

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Ninety percent of hospital expenses for 365 days after Medicare benefits are exhausted.

The number of those who might potentially benefit from this coverage has, however, declined sharply since 1981. Since the imposition of the Medicare prospective payment system, the average length of Medicare hospital stays has decreased from 9.5 to 7.5 days. Part of the reason for this decrease is the sharp drop in the number of very long hospital stays. As table VIII below illustrates, the number of Medicare patients in the hospital longer than 60 days has dropped from very small to almost negligible. Specifically, whereas in 1981, some 3 percent of hospital visits for Medicare patients lasted longer than 60 days, in 1984 that number had dropped sixfold to one-half of 1 percent. The percentage of cases 90 days or longer has dropped over the same time from 0.7 percent of 0.16 percent. The number of stays 120 days and longer has fallen from 0.02 percent to 0.0017 percent. In other words, in 1984, the likelihood for a Medicare beneficiary to find him or herself in a hospital longer than 60 days was 1 in 1,428. The odds of a Medicare beneficiary being hospitalized longer than 90 days was 1 in 5,000. Those requiring hospital stays longer than 120 days totalled only 56 nationwide in 1984, making the odds of needing coverage 1 in about 500,000.

TABLE VIII.—LENGTHY HOSPITAL STAYS PAID FOR BY MEDICARE (1984)

| Length of stay | Percent of total cases | | Odds for all 65 and older | |
|---|---|---|---|---|
| | 1981 | 1984 | 1981 | 1984 |
| 60 days of more | 3 | 0.5 | 1/250 | 1/1,428 |
| 90 days of more | 0.7 | .16 | 1/1,000 | 1/5,000 |
| 120 days of more | .02 | .0017 | 1/35,000 | 1/500,000 |

Under the NAIC Model Standards, service benefit policies are also requried to cover at least 20 percent of Medicare-approved charges for part B medical expenses. This means that they need not provide protection against the total actually billed the beneficiary. As discussed in section II, if a doctor does not accept the Medicare rate as payment in full, the typical service benefit policy provides no coverage against the amount billed above and beyond what Medicare finds reasonable. For example, a 72-year-old woman with a standard policy is billed by her doctor $100 for an office visit. Medicare then determines that the reasonable charge for the visit is not $100, but $60, and pays the woman 80 percent of that $60—$48. Her Medigap policy would pay her $12 (20 percent of the Medicare-approved charge), leaving the woman to pay the remaining $40 out of her own pocket.

(2) *Hospital indemnity.*—These Medigap policies, on the other hand, pay a flat stated number of dollars per day of Medicare-approved hospitalizations. This type of policy pays benefits only if the insured is hospitalized, and as such provides no protection against large medical bills not associated with a hospital stay. Also, because hospital indemnity policies pay a fixed amount, their worth is eaten away over time by inflation. These policies may also contain restrictions on when benefits will begin and the maximum

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amount the policy will pay per day of illness. For example, a policy may pay $100 a day in a hospital, but will pay only if the policyholder has been in the hospital longer than 60 days and will pay a maximum of $5,000 per spell of illness. Because the odds of being hospitalized longer than 60 days is very small and continually shrinking, this policy may be of limited value to the average older American. On the positive side, many such hospital indemnity policies are less expensive than service benefit policies and pay benefits even if another policy is paying.

Many consumer advocates and State and Federal officials advise against the purchase of this type of Medigap policy. In their June 1984 issue, Consumer Reports stated:

> Hospital indemnity policies are widely advertised, often endorsed by celebrities. They are easy to understand. Compared to most health insurance, they are cheap. None of that, in CU's opinion, is reason enough to buy one.

(3) *Dread disease.*—These Medigap policies insure against only specific diseases. The preponderance of these policies are cancer policies, but others include insurance against other dread diseases such as leukemia, spinal meningitis, rabies, polio and the like. They provide very narrow coverage and only provide benefits if one gets the specific disease the policy covers. Although these policies are not typically offered to the elderly exclusively, many such dread disease policies are purchased by older Americans. However, many of these policies duplicate Medicare coverage. In its landmark 1981 report, "Cancer Insurance: Exploiting Fear For Profit," the committee documented many problems associated with the sale and purchase of dread disease policies.

(4) *Long-term care (nursing home) indemnity.*—There have historically been relatively few insurance policies which cover the majority of expenses associated with long-term care. The same holds true today, but very recently there has been a considerable increase in interest among many insurance companies in developing such policies. A substantial amount of growth in the market for long-term care, care insurance is expected as the number of Americans needing such care skyrockets into the next century.

Of the limited number of long-term care policies available today, the vast majority are of the indemnity type and have very strict criteria for determining eligibility for benefits. Many will pay a fixed amount (typically considerably less than the total cost) per day of skilled nursing facility care certified by Medicare. This coverage often duplicates that offered by standard service benefit Medigap policies. Other long-term care policies offer a fixed amount per day of care in an intermediate or custodial nursing home, but only after a hospital stay or skilled nursing facility stay. Some of these policies do not pay benefits until the holder has been institutionalized for a year. This might easily leave one holding such a policy footing a bill of $20,000 to $40,000 before getting any assistance. Many long-term care policies limit benefits to stays of 3 years. Since 1 of 5 of those requiring nursing home care stay for 5 years or more, these policies may not alleviate the pauperization of the policyholder and comprehensiveness of coverage. Costs of policies range from $20 to $300 a month.

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Long-term care indemnity policies currently offered typically exclude certain major illnesses such as Alzheimer's disease from coverage which accounts for about 50 percent of all custodial nursing home admissions.

The irony of all this is, of course, that senior citizens generally have purchased Medicare supplementary policies with the hope and expectation that it will cover all of the medical expenses for which Medicare will not pay. Insurance agents often represent to their prospective customer: "This policy will pay for everything Medicare doesn't cover." The reality is that most Medigap policies exclude from coverage all items not covered by Medicare.

It is understandable then why the elderly have been disappointed in the Medigap policies in the past and why they will continue to be disappointed in the future. Those who will be the most disappointed are those who have purchased several policies only to learn that the aggregate will not provide them with the health security they seek.

This is not to suggest that all Medicare supplementary policies are worthless, but only that their benefits are often exaggerated. Most experts would agree that there is economic value in the purchase of one Medigap policy, particularly from Blue Cross/Blue Shield or from a private health insurance company which, like Blue Cross, returns 90 to 95 percent of what they take in. The remainder is burned up in expenses, retained by the company as profit or divided up among its agents as commissions.

*B. Value of Medigap policies*

It is difficult for seniors to be prudent Medigap shoppers. There is little in the way of information to allow for comparison shopping. Measures of the actual worth of individual Medigap policies do sometimes exist, but are often not accessible to the average consumer. The following pages are devoted to these measures of policy worth and sugestions for consumers in choosing Medigap insurance.

One measure of an insurance policy's worth is called the loss ratio. Loss ratio is the proportion of gross premiums which, on the average, is returned to policy holders in the form of benefits. As such, its an indicator of economic value of policy form or forms offered for sale by an insurance company. Loss ratios are usually expressed in percentages. For example, if the loss ratio for a year (or other specific period) were 55 percent, this should mean that total benefits paid to policyholders—for illnesses starting during the period—would amount to 55 percent of the premiums which the had paid. Thus, from a consumer's point of view, the higher the loss ratio, the better the policy.

Although loss ratios can be used as measures of economic value, they do not reflect other factors which should be considered in determining economic value, such as:

What other insurance is available covering the same illness or other contingency;

The individual's financial situation; and

If the individual has other insurance covering the same contingency, will benefits payable on the new or existing policy be

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released accordingly under provision for "coordination of benefits."?

Also, it is important to note that loss ratios are often presented as the average of all the insurance company's accident and health policies. This can afford some misleading information relative to individual Medigap policies. This presentation format may incorrectly lead one to believe that all of a company's health insurance policies, including Medigap, can be expected to return on average the same percentage of premiums taken in. Some examples taken from the 1985 Argus Guide and a 1975 report by the Wisconsin Department of Insurance serve to demonstrate this point well. While Mutual of Omaha Insurance Co. is listed a national loss ratio of 71 percent for all of its accident and health policies, its individual Medigap policies in force in Wisconsin have loss ratios from 37 percent to 57 percent with an average of 46 percent. Banker's Life and Casualty has an Argus listing of 73 percent loss ratio, yet its individual Medigap policies in Wisconsin have loss ratios ranging from 17 percent to 53 percent with an average of 42 percent. United American Insurance Co. has a listed loss ratio of 44 percent in the 1985 Argus Guide, yet its Medigap policies in the State of Wisconsin had loss ratios ranging from 11 percent to 68.1 percent with an average of 26 percent per policy in force.

Another important piece of information which should be considered when selecting an insurance policy is the relative financial position of the insurance company. Probably the most frequently used reference book in the insurance trade is Best's Insurance Report. Best's, available in some public libraries, gives an independent assessment of most insurance companies' financial strength, in the form of letter grades A+ to C. A high rating (toward A+) generally means that a company is financially sound. Many insurance companies and their agents use a high Best's rating as a major selling point for their policies.

In its June 1984 report on Medigap insurance, Consumer Reports offered the following suggestions for consumers using Best's:

> Unless you have independent knowledge of a company's financial condition, CU suggests buying health, life, or disability insurance only from a company rated A or higher. At best, the bankrupty of your health insurance carrier would subject you to a lot of redtape. At worst, it could leave you without coverage. . . . In our ratings, we regarded a Best's rating of A as normal. We gave extra credit to those companies that had an A+, and penalized those with grades below A. As nonprofit organizations, Blue Cross and Blue Shield plans are not rated by Best's.

It should be mentioned that while the relative financial strength of an insurer should be a part of any consumer evaluation of Medigap policy alternatives, it should not be used as the sole judge of a policy's worth. It is not impossible for a company to be strong financially because of its low benefit pay out rate.

Two other important elements of Medigap policies are the limitations they include related to preexisting and renewablity.

An important limitation of some policies is the presence of preexisting clauses. Some Medigap policies contain waiting periods and/or exlusions from coverage for conditions the policy holder has

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when he or she bought the policy. A common waiting period is six months. For example, if a senior has a kidney ailment at the time he or she buys a Medigap policy with a standard 6 month preexisting condition waiting period. If the senior then as kidney failure two months later and then has very large medical bills not covered by Medicare, the Medigap policy will pay no benefits because the waiting period has not been met.

Another important consideration in evaluating Medigap policies is the renewability of policies. If a policy contains a clause which will allow the company to cancel the policy at any time, this means that the policy holder despite having paid premiums as requested, could be left with no protection. If, however, the policy states clearly that it is guaranteed renewable, the company cannot cancel the policy as long as the insured pays his or her premiums. This does not prohibit the company from raising premiums for the policy.

Consumers should also be on the look out for policies which are designated as "class cancellable" or "conditionally renewable." Under these types of policy provisions, the Medigap insurer cannot cancel just an individual policy, but it can cancel a senior citizen's policy if it cancels the entire group of policies of which the single policy is a part (all policies in one state, for example). There are also policies which state that they are renewable at the option of the company. Such Medigap policies can be cancelled on 30 days' notice, regardless of whether all the policies within its group are maintained.

While statistics on such group cancellations are not available, it is not uncommon for policies to be cancelled once the original pool of policy holders begin to put in more and more benefit claims against their policies. For example, in 1984 a Texas company that had been active in the Medigap field began cancelling the Medigap policies it had issued in the previous few years, apparently because it was losing money on them. It was reported that some 70,000 people were affected. The policies were not guaranteed renewable.

Experts also advise those senior citizens who can do so to buy group health insurance as opposed to individual policies. Most health insurance in America is sold on a group basis. Most typically employers provide coverage to their employees. Group plans afford many advantages. For one thing, they are less expensive since it costs less to insure a group of 100 individuals. Group policies are ususally more comprehensive as well. Group policy enrollees rarely have to take a physical exam to qualify for coverage and there are fewer exclusions from coverage and waiting periods prior to coverage are less common.

The problem with most group health plans has been that the group was generally made up of employees and when an individual retired, he or she left the group and hence lost coverage. However, in most cases senior citizens can convert their group coverage to an individual policy with the same company but the price of continuing the policy will generally be higher and the coverage may be more limited.

*C. How Medigap is sold*

As with many products and services, a key to a successful Medigap company is finding an effective way of marketing the product.

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Medigap companies have historically been aggressive and innvovative in their marketing approaches. There are four general modes of selling Medigap insurance to the elderly:

(1) *Conversion.*—This selling mode, as described briefly above, involves the conversion of a health insurance policy held through one's job (usually as benefit) to a separate policy upon retirement. Typically, a retired person is forced to convert from his employer's group policy to an associated individual policy. The conversion from group to individual may require a prior medical exam, increased premiums and more limited coverage.

(2) *Mail order.*—A substantial number of Medicare supplement and indemnity plans are sold to the elderly by mail.

(3) *Salesmen.*—A good deal of Medigap insurance is sold by salesmen who visit seniors in their homes, in senior centers, hospitals and elsewhere. These salespeople are typically aggressive, fast talking, and pressuring. While there are some outstanding and very reputable Medigap sales agents, many are out to make the sale and will employ whatever tactics they feel will make the sale most probable. Medigap salespeople often have a very strong financial incentive to make sales. Most work on a commission basis, meaning that their income is a percentage of the total premiums taken in by the company from policies the agent has sold. This commission is often quite high. Data supplied to the subcommittee by the Wisconsin Department of Insurance indicates that agent commissions range from 0 percent to 70 percent of the total first year premium paid per policy sold.

In its landmark 1978 report "Abuses in the Sale of Health Insurance to the Elderly," the committee indentified widespeard abusive practices by Medigap salespeople. A litany of abuses were detailed ranging from overloading by selling elderly more insurance than they need, to make the check out to me schemes in which the agent would pressure the elderly consumer to sign a check over to the agent on the premise of purchasing a Medigap policy when in fact no coverage was being provided. The subcommittee, in an effort to determine if abuses persist, has conducted a follow up investigation in this area. The results of this investigation, detailed in section IV of this report, indicate that abuses in the sale of Medigap remain pervasive.

(4) *Television.*—The most prevalent and fastest growing type of Medigap marketing is through television advertising. Insurers offering mostly mail order Medigap coverage employ well known trusted television personalities to make emotional appealing endorsements of their products. The facts presented in these ads are often truthful. They are slick. Very rarely do the ads contain direct untruths, rather they provide incomplete and misleading information. Typically, these ads stress the potential financial catastrophe of a long drawn out hospital stay. They advise seniors that without additional protection, that they could find themselves with over $30,000 in hospital bills alone. What they don't mention is that only very few people will ever have a hospital stay of such lengths. Many of these TV ads imply that the policy being endorsed "pays everything

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Medicare doesn't." What they fail to say is that this is only for Medicare-covered services and Medicare approved charges, leaving as much as half of health care costs uncovered. These advertisements play upon seniors' fear of rising health care costs and Medicare inadequacies, their great desire for health care security, as well as seniors' trust of and good feelings toward these television celebrities. These advertisements have been very successful, inducing thousands of seniors to buy the endorsed Medigap policy.

*D. What seniors know about Medicare and Medigap*

Considering the complexity of the subject, the lack of standardization, and the lack of useful consumer information, it is not surprising that senior citizens are often confused about Medigap. Many older Americans lack general knowledge about what Medicare and Medigap cover. A 1977 survey found, for example, that some 80 percent of seniors believed that Medicare would pay for nursing home care should they need it.

On May 23, 1986, the Subcommittee on Health and Long-Term Care sent out questionnaires to all 647 Area Agencies on Aging in the United States. The questionnaire was an attempt to update, on a national scale, the results of the identical questionnaire administered in 1977 to a sample of Florida residents by Zarrel V. Lambert, Liberty National Professor of Marketing in the School of Business at Auburn University mentioned previously. As the author himself stated in response to this findings of his exploratory study:

> "Many elderly consumers lack adequate knowledge about the financial risks associated with hospitalization, and the basic aspects of health insurance important in buying medigap policies."

His results, as well as those of the subcommittee, strongly demonstrate the lack of understanding most older people have regarding Medicare and policies which supplement its coverage.

According to Lambert, "The multitude of channels utilized in selling insurance create many opportunities for older consumers to make purchase decisions which waste, in one manner of another, substantial proportions of their limited funds or which leave them with protection expectations that will not be fulfilled should certain major illness occur." Lambert surmised that the presence of such large numbers of ill-prepared consumers adds fuel to questionable behavior and practices on the part of Medigap insurance sellers. The subcommittee's survey validated the Lambert 1977 survey.

Three weeks following the distribution of the survey, the subcommittee had reviewed responses from over 9,000 senior citizens. The analysis of their response follows.

THE 1986 QUESTIONNAIRE TO SENIOR CENTERS

The 1986 survey conducted by the Subcommittee on Health and Long-Term Care was begun on May 23, 1986. As was stated earlier, questionnaries were mailed to 647 Area Agencies on Aging, who in turn administered the survey to no fewer than 20 seniors at a senior center in their community. At the time this report went to press, about 9,000 senior citizens had responded to the survey.

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The following charts, prepared in early 1986 by the Montgomery County (Maryland) Office of Consumer Affairs, provided a detailed analysis of the cost of typical Medicare supplemental health insurance policies.[3]

The subcommittee's survey elicited responses from seniors across the United States. Only four States, Montana, North Dakota, Wyoming, and Connecticut failed to respond. We found that the level of general understanding regarding Medicare coverage and its gaps was minimal. For example, only one-third of participating seniors realize that hospital insurance policies and coverage depends on the cause of illness. Three-quarters expect full coverage of hospital and medical expenses by their insurance company regardless of cost and only 8 percent of those participating understood the reasoning behind the loss ratio. The remainder of that 8 percent seemed to perceive a high loss ratio as a sign of rising premiums and unreliable coverage in the future.

The majority of seniors responding felt that Medicare would cover care in the home absent the need for skilled care, and that nursing home care would be covered. Both views are incorrect. Medicare will pay for home care if skilled care and other requirements are satisfied. Medicare seldom pays nursing home care, except if skilled care is required and even then a coinsurance requirement applies after the 20th day in such a facility.

The overall comparison between 1977 and 1986 is startling, in terms of consistency over time. In the last 8 years, seniors appear to possess less understanding of health insurance and its coverage. Attached are the responses to questions administered by AAA directors to senior citizens at senior citizen centers in 1986.

TABLE A

| Question | Percentage answering correctly (age 65 and over) | |
|---|---|---|
| | 1986 | 1980 |
| (1) A policy that promises to pay a certain amount for each day a person is hospitalized usually provides benefits to a senior citizen that are quite different from the benefit provided by policies designed to pay hospital and doctor expenses that are not covered by Medicare. (True) | 29 | 48 |
| (2) An indemnity policy which promises to pay a certain amount for each day a person is hospitalized, say $40, typically will not pay more than this amount regardless of how much the hospital, doctor, and drug charges are each day. (True) | 50 | 65 |
| (3) A "preexisting conditions" clause in a hospital insurance policy means the company can refuse to pay claims due to current illness related to or developing from an illness or condition you had when you bought the policy. (True) | 61 | 75 |
| (4) Some health insurance policies—known as dread disease policies—will pay only if the policyholder gets a certain disease covered by the policy such as cancer. (True) | 50 | 64 |
| (5) Health insurance policies sometimes contain a clause that excludes payment for expenses resulting from certain kinds of illnesses or diseases to certain parts of the body. (True) | 44 | 56 |
| (6) Policies with a short time period during which claims can be denied due to preexisting conditions are usually the most advantageous for persons 65 and over. (True) | 22 | 29 |
| (7) If a company states that a hospital insurance policy is guaranteed renewable for life, this means the premiums can not be raised to exorbitant levels during the lifetime of the policyholder. (False) | 43 | 42 |

[3] See pages 34 FF.

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TABLE A—Continued

| Question | Percentage answering correctly (age 65 and over) | |
|---|---|---|
| | 1986 | 1980 |
| (8) If a hospital insurance policy states it will pay certain hospital expenses, say so much a day for hospitalization, this means it will always pay for these expenses regardless of the cause of the illness that resulted in hospitalization. (False) | 33 | 26 |
| (9) If a policy states that certain hospital and medical expenses will be paid, the company must pay for these expenses regardless of how much they add up during a year or during the policyholder's lifetime. (False) | 25 | 22 |
| (10) Generally it is unwise for persons 65 and over to buy a hospital insurance policy on which the issuing company has a high loss ratio where a high percentage of the premiums collected are paid out in claim losses because the company in the future may raise premiums, cancel the policy, resist paying claims, or become financially unsound. (False) | 8 | 3 |
| (11) A person who cancels a hospital insurance policy and then immediately buys another policy will be without full coverage for a period of time because of "preexisting conditions" and/or "waiting period" clauses in the new policy. (True) | 61 | 63 |
| (12) In order to be covered by Medicare medical insurance (part B), most people 65 and over do not have to pay monthly premiums. (False) | 59 | 75 |
| (13) Medicare hospital insurance (part A) does not pay for the first $104 of hospital expense incurred by a person in each Medicare benefit period. (True) | 60 | 71 |
| (14) Beginning with the 31st day in a hospital, a person covered by Medicare hospital insurance (part A) must pay the first $26 per day of hospital expense. (False) | 7 | 17 |
| (15) A person covered by Medicare who is in the hospital longer than 90 days must pay the first $52 per day of hospital expenses beginning with the 91st day, and Medicare hosptial insurance (part A) pays the balance until a lifefime total of 60 reserve days of Medicare coverage is used. (True) | 29 | 46 |
| (16) If a person is admitted to a skilled nursing facility following at least a 3-day stay in the hosptial, Medicare hospital insurance (part A) will pay for all covered services for the first 20 days in the nursing facility if certain conditions are mre. (True) | 31 | 55 |
| (17) From the 21st through the 100th day in a skilled nursing facility, Medicare hospital insurance (Part A) helps pay covered services, but the person must pay the first $13 per day of expense for covered services. (True) | 19 | 42 |
| (18) Medicare medical insurance (part B) will pay only what is considered to be a "reasonable" charge or fee. If a doctor or hospital charges more that this amount, the person must pay the difference (True) | 66 | 80 |
| (19) Medicare medical insurance (part B) helps pay outpatient hosptial care, outpatient physical therapy and speech pathology services, and home health care which are not cevered by Medical hosptial insurance (part A). (True) | 28 | 51 |
| (20) Medicare medical insurance (part B) helps pay for doctor's services received in his office, in a hosptital, in a skilled nursing facility, and in a person's home. (True) | 35 | 77 |
| (21) If a person is an inpatient in a hospital, Medicare medical insurance (part B) pays 100 percent of the resonable charges by doctors for services in radiology and pathology. (True) | 16 | 35 |
| (22) Laboratory services and other diagnostic tests, except routing examinations, are covered by Medicare medical insurance (part B). (True) | 24 | 63 |
| (23) Medicare medical insurance (part B) does not pay for the first $75 of covered or Medicare approved medical expenses in each calender year. (True) | 55 | 77 |
| (24) Medicare medical insurance (part B) pays for no more than 80 percent of covered medical expenses, disregarding treatment for mental illness. (True) | 50 | 75 |
| (25) The home health care coverage under Medical hospital insurance (part A) and Medicare medical insurance (part B), may be combined under some circumstances to help pay for more than 100 days of home health care in a calendar year. (True) | 13 | 34 |
| (26) In order for home health to be covered by Medicare medical insurance (part B), the person must require part time skilled nursing care or therapy as determined by a doctor and the person must be convined to their home. (True) | 36 | 51 |

The questionnaire obviously sparked much interest and curiosity at the senior centers about the senior's Medicare coverage and supplemental insurance. Numerous requests were made for a copy of the followup report on the survey and the answers to the questions. Many senior centers even brought in an expert in the field to

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answer questions raised after the survey was completed. Directors are now attempting to develop educational programs for the seniors to enligthen them on Medicare and medigap. Excerpts expressing such concern follow:

> In implementing this survey, it became apparent to me that the AAA's need to provide additional training regarding Medicare and medigap insurance.
>
> Most of the seniors were even unclear as to the differences and costs of Medicare part A and Medicare part B.
>
> You may believe, however, that this is a topic near and dear to their hearts and the questionnaire precipitated quite a lively discussion and many questions.
>
> We have been educating Berkshire seniors, with speakers, articles in our senior newsletter, and informational material distributed to all; the medigap situation is often confusing, however, particularly when we are being barraged daily with mail offers of complete medigap coverage by private companies.
>
> It was an opportuntiy to do this survey. It told us where help is needed. The center director said that she has more questions on Medicare than on any other subject.
>
> Many people don't know what benefits they have, or what is covered under Medicare. They can't really buy a supplemental policy if they don't know what is already covered under Medicare.
>
> This certainly was a long and complicated questionnaire, but the 44 persons present in our dining room that took it stood by to provide feed back for your work. It's obvious that a large percentage are uniformed of the details of the coverage they carry. As one person expressed it, she hadn't had the need, therefore she didn't know the technicalities.
>
> The questions raised a great deal of interest among the senior citizens present. We would like to have an answer/explanation sheet for future discussion purposes.

Another finding of the subcommittee related to the general confusion seniors have regarding insurance due to its complexity. The following excerpts validate this observation:

> While we applaud your efforts to reopen the investigation of Medigap insurances, we feel the survey questions were too technical and complex to give you a fair reading of the knowledge of senior citizens about the basic attributes of health insurance. A representative of our area's Legal Aid office (who we consider to be an expert on Medicare and Medigap insurance) was present when we administered the survey and even he had difficulty answering the questions as stated.
>
> One woman told me that she was college educated and still found it difficult to answer questions. A retired nurse said it was difficult to answer the questionnaire. One conclusion we all agreed on was that Medicare is confusing. We applaud you for giving us the opportunity to give input

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into the system and for checking with us to see where we are in understanding the Medicare program.

The questions were confusing and frustrating, and I realize that it is the extent of this confusion that this survey is partly intended to estimate.

Initially, we were uncertain whether the large number of "don't know" responses was because participants did not understand the rather complex questions or because they did not understand the issues involved. We realized, however, that the convoluted and complicated nature of the entire health insurance system negates the ability to ask simple questions, so the responses would be valid in either case.

It was very clear to me that these people I work with need considerable educating in just what Medicare covers and does not cover. What a shame to have to depend on a system one cannot understand, let alone afford:

The majority of responses were accompanied by statements of support; expressions of agreement that Medicare is complex, inadequate and in need of reform:

Several elders at this meeting expressed concern about friends who have overlapping policies, some asked specific questions about their own policies, and others voiced their concern about the growing number of apparently sophisticated but confusing television advertisements for Medigap policies.

I applaud the work you are doing. If there is a way to communicate information or (God forbid) regulate the Medigap insurers to no longer allow them to make claims that are not true, you will have accomplished a miracle.

Clearly, the complexity and the confusion surrounding both Medicare and Medigap insurance leave the elderly as prime targets, that is, sitting ducks for slick, smooth talking, unethical salespersons who exploit the elderly's greatest fear—being left penniless and homeless due to long trem care bills.

Medigap insurance and changes in Medicare regulations and copayments are still very complex. Wouldn't it be simpler to have comprehensive national health insurance for all our citizens such as most other industrialized nations provide? Medicare is certainly becoming less and less comprehensive as the years go by. The real issue, it would seem to me, is an economic one: how can deductibles keep increasing at 15 to 20 percent per year when social security COLA's average is only 3 percent.

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To help seniors evaluate Medigap policies available in their State, the Maryland Department of Aging analyzed those policies in detail and prepared the following brochure spelling out the differences on coverage.[4]

[4] Policies noted in these charts were selected from those in force in Maryland at the time. Differences in State regulation and corporate policy marketing may result in policy difference from State to State.

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| SERVICES | MEDICARE HOSPITAL INSURANCE PART A | AMERICAN INTEGRITY SENIOR SUPPLEMENT FORM SS-65-MD | AMERICAN INTEGRITY MASTER SUPPLEMENT FORM MMS-65-P-MD | AMERICAN NATIONAL LIFE FORM CMS-S-49 | BANKERS LIFE & CASUALTY MEDICARE PLUS FORM CA 7SR PLAN I |
|---|---|---|---|---|---|
| PREMIUM OR SUBSCRIPTION CHARGES | NO CHARGE — Credited for deductions under the Social Security Program | Age 65-72 $581.65 per year<br>73-77 - 660.25 per year<br>78-82 - 740.10 per year<br>83 + - 760.15 per year | Age 65-69 - $768.20 per year<br>70-74 - 822.50 per year<br>75-79 - 865.50 per year<br>80-84 - 885.70 per year<br>85 + - 940.50 per year | AGE MALE FEMALE<br>65-69 $599 $496 per year<br>70-74 674 561 per year<br>75-79 800 654 per year<br>80-84 939 756 per year | Age 65 $480.25 71 $586.58 per year<br>66 - 496.05 72 - 617.76 per year<br>67 - 504.65 73 - 652.45 per year<br>68 - 518.50 74 - 683.76 per year<br>69 - 538.61 75 + 728.10 per year<br>70 - 568.52 |
| REGISTRATION FEE | NONE | $10 with application | $10 with application | NONE | NONE |
| PRE-EXISTING HEALTH CONDITIONS | NO RESTRICTIONS Covered from 1st day. | 6 month waiting period for condition for which advice or treatment was received by physician within 6 months prior to Effective Date | 30 day waiting period for any condition for which advice or treatment was received by physician within 6 months prior to Effective Date | 6 month waiting period due to disease or physical condition [illegible] or treatment within 6 months prior to the effective date of coverage | 90 day waiting period for medical condition that treatment or advice was recommended by doctor within 6 months before effective date |
| DEDUCTIBLE ON ENTRY TO HOSPITAL | You must pay $492. Covers all of hospital costs for 60 days. | Pays the Medicare $492 deductible | Pays the Medicare $492 deductible | Pays the Medicare $492 deductible | Pays the Medicare $492 deductible |
| COPAYMENT FOR THE NEXT 30 DAYS | You pay $123 per day. Medicare pays balance of hospital costs | Pays the Medicare $123 copayment each day | Pays the Medicare $123 copayment each day | Pays the Medicare $123 copayment each day | Pays the Medicare $123 copayment each day |
| COPAYMENT FOR THE NEXT 60 DAYS "LIFETIME RESERVE" | You pay $246 per day. No portion of this period may be used again | Pays the Medicare $246 copayment each day | Pays the Medicare $246 copayment each day | Pays the Medicare $246 copayment each day | Pays the Medicare $246 copayment each day |
| MAXIMUM PERIOD OF COVERAGE FOR ANY ONE sENEFIT | 90 days plus any unused portion of "Lifetime Reserve." | Continues at 80% of charges for an additional 365 days in LIFETIME after Medicare benefits are exhausted | Continues at 100% of reasonable charges incurred while confined | Continues at 80% of Medicare Eligible hospital expenses not covered by Medicare for 365 more days or all benefit periods combined | Continues at 100% of the Usual and Customary hospital care after the Medicare benefits are exhausted |
| SKILLED NURSING FACILITY | Pays 100% for 1st 20 days with a copayment of $61.50 per day for the next 80 days. NO CUSTODIAL CARE!! | Pays the Medicare copayment of $61.50 per day from the 21st thru the 100th day | Pays the Medicare copayment of $61.50 per day from the 21st thru the 100th day | Pays the Medicare copayment of $61.50 per day from the 21st thru the 100th day | *NOT COVERED |
| MEDICAL COVERAGE FOR PART B | PART B $75 deductible each year. Your cost is $15.50 per month | Pays the Medicare $75 deductible | Pays the Medicare $75 deductible | NOT COVERED You pay the 1st $75 | NOT COVERED. You pay $75 deductible |
| OUTPATIENT CARE Physician Care for Hospital or Office Services, Surgery, Anesthesia, X Ray, Laboratory, Injections, Splints, Casts, Dressings, Radiation Therapy, Physical Therapy, Ambulance, Prosthetics, etc. | Pays 80% of reasonable fees and charges | Pays 20% of Medicare eligible expenses for a maximum of $5,000 in a calendar year | Pays 20% of Medicare Approved Charges — IN ADDITION — After you pay $200 in excess charges, company pays 80% of excess charges | Pays 20% of Mc-Scare allowable charges | **Pays 20% of Medicare approved charges |
| OUTPATIENT PRESCRIPTION DRUGS | Pays 100% as an IN-PATIENT ONLY. | NOT COVERED | NOT COVERED | NOT COVERED | NOT COVERED |
| RENEWABILITY OF CONTRACT | Cannot be cancelled. | Guaranteed renewable for life | Guaranteed renewable for life | Guaranteed renewable | Guaranteed renewable for life |
| TRAVEL RESTRICTIONS OUT OF AREA | Covered in U.S. or possessions. May use Canada or Mexico under certain conditions. See the Medicare Handbook. | Not covered outside of United States | Not covered outside of United States | Coverage is same as provided by Medicare | Covered to same extent as if received in the U.S.A. |
| Medicare & Insurance Supplement Comparison Guide for Those for the consumer use by [Montgomery County, Maryland] and prepared by [illegible] Division of Community | [redacted] | No health questions in application | No health questions in application | | *Nursing Home Care and Part B deductible available at additional cost<br>**Higher Part B benefits also available |

3



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| BENEFITS | MEDICARE HOSPITAL INSURANCE PART A | BENEFIT TRUST LIFE FORM MSP-103 MD | BLUE CROSS/BLUE SHIELD "HS" LOW OPTION PLAN | BLUE CROSS/BLUE SHIELD "HX" HIGH OPTION PLAN | COLUMBIA LIFE FORM MSP (100) |
|---|---|---|---|---|---|
| PREMIUM OR SUBSCRIPTION CHARGES | NO CHARGE -- Credited for Deductions under the Social Security Program | Age 65 - 0 794.81 per year<br>66-69 - 887.50 per year<br>70-74 - 1,035.74 per year<br>75-79 - 1,203.00 per year<br>80-84 - 1,410.30 per year<br>85 + - 1,657.58 per year | $311.28 per year<br>Covers under 65 on Medicare | $1,125.72 per year<br>Covers under 65 on Medicare | Age-65-69 $578 per year<br>70-74 - 669 per year<br>75-79 - 748 per year<br>80-84 - 818 per year<br>85-99 - 888 per year |
| REGISTRATION FEE | NONE | NONE | NONE | NONE | NONE |
| PRE-EXISTING MEDICAL HEALTH CONDITIONS | NO RESTRICTIONS Covered from 1st day. | 45 day waiting period for a condition for which medical advice or care was recommended during the 6 month's before the Policy Date | NO WAITING PERIOD NO HEALTH QUESTIONS | NO WAITING PERIOD NO HEALTH QUESTIONS | 6 month waiting period for any condition for which medical advice or treatment was given within a six month period before Policy Date |
| DEDUCTIBLE OR ENTRY TO HOSPITAL | You must pay $492. Covers all of hospital costs for 60 days | Pays the Medicare $492 deductible | Pays the Medicare $492 deductible | Pays the Medicare $492 deductible | Pays the Medicare $492 deductible |
| COPAYMENT FOR THE NEXT 30 DAYS | You pay $123 per day. Medicare pays balance of hospital costs | Pays the Medicare $123 copayment each day | Pays the Medicare $123 copayment each day | Pays the Medicare $123 copayment each day | Pays the Medicare $123 copayment each day |
| COPAYMENT FOR THE NEXT 60 DAYS "LIFETIME RESERVE" | You pay $246 per day. No portion of this period may be used again. | Pays the Medicare $246 copayment each day | Pays the Medicare $246 copayment each day | Pays the Medicare $246 copayment each day | Pays the Medicare $246 copayment each day |
| MAXIMUM PERIOD OF COVERAGE FOR ANY ONE BENEFIT | 90 days plus any unused portion of "Lifetime Reserve." | Continues at 80% of Medicare eligible covered charges for hospital services for up to the 525th day | Covers 80 days plus any unused portion of the "LIFETIME RESERVE." | Continues at 80% of Medicare Approved Expenses for an additional 365 days | Continues at 80% of Medicare Eligible Expenses for an additional 365 days in your LIFETIME |
| SKILLED NURSING FACILITY | Pays 100% for 1st 20 days with a copayment of $81.50 per day for the next 80 days NO CUSTODIAL CARE! | Pays the Medicare copayment of $81.50 per day from the 21st thru the 100th day, and then, 80% of daily room rate for an additional 80 days if needed. | Pays the Medicare copayment of $81.50 per day from the 21st thru the 100th day. | Pays the Medicare copayment of $81.50 per day from the 21st thru the 100th day. | Pays the Medicare copayment of $81.50 per day from the 21st thru the 100th day. |
| MEDICAL COVERAGE FOR PART B | PART B $75 deductible each year. Your cost is $75.50 per month. | *Pays the Medicare $75 Deductible | Pays the Medicare $75 deductible for emergency services in hospital or in physicians' offices. | Pays the Medicare $75 deductible | *NOT COVERED |
| OUTPATIENT CARE Physician Care for Hospital or Office Services, Surgery, Anesthesia, X-Ray, Laboratory, Injections, Splints, Casts, Immunizations, Radiation Therapy, Physical Therapy, Ambulance, Prosthetics, etc. | Pays 80% of reasonable fees and charges. | Pays 20% of Medicare covered charges | NOT COVERED | Pays 20% of Medicare approved expenses | **Pays 20% of Medicare Eligible Expenses OR the difference between Usual, Reasonable and Customary Charge and amount paid by Medicare, whichever is highest |
| OUTPATIENT PRESCRIPTION DRUGS | Pays 100% as an IN-PATIENT ONLY. | Pays 80% after a Hospital stay and before 5cmh of illness each | NOT COVERED | Pays all costs at Participating Pharmacies except for a $5 deduction on each prescription | NOT COVERED |
| RENEWABILITY OF CONTRACT | Renewal by choice. | Guaranteed renewable for life. | Reserves right to cancel. | Reserves right to cancel. | Guaranteed renewable for life. |
| TRAVEL RESTRICTIONS OUT OF AREA | Covered in U.S. or possessions. May use Canada or Mexico under certain conditions, See the Medicare Handbook. | Will cover Canada or Mexico out of United States but as provided by Medicare. | Foreign hospital coverage for maximum of $600 | Covers reasonable charges same as if you were home | Covers same areas as provided by Medicare |
| Medicare & Insurance Standard Comparison Guide for 1988 (or the provision you by Montgomery County, Maryland and prepared by John L. Election of Colorado. | | *May eliminate [illegible] to lower premium | | | *Optional rider available to cover the deductible<br>**Optional riders available to pay higher benefits |

4



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| CONTINENTAL CASUALTY CNA XTRA CARE PLAN I FORM P1-87730-A10 | CONTINENTAL CASUALTY CNA XTRA CARE PLAN II FORM P1-87730-A10 | GOLDEN RULE MEDIGAP BASIC FORM GR-H-1.1a | GOLDEN RULE MEDIGAP PLUS FORM GR-H-1.1bP | LIFE & HEALTH OF AMERICA FORM LHA 888-A-MB | MUTUAL OF OMAHA MUTUAL CARE FORM MM -- SERIES 13921 |
|---|---|---|---|---|---|
| AGE MALE FEMALE<br>65-69 $376.56 $326.01 per year<br>70-74 453.83 393.73 per year<br>75-79 541.98 454.34 per year<br>80-84 622.24 526.32 per year<br>85 + 715.70 603.39 per year | AGE MALE FEMALE<br>65-69 $551.65 $486.73 per year<br>70-74 666.56 581.94 per year<br>75-79 802.24 702.73 per year<br>80-84 925.21 823.62 per year<br>85 + 1,082.05 954.15 per year | ALL AREAS<br>$ 100.86 per year | Zip Code Areas<br>208, 209,212, 214-218<br>$831.96 per year<br>Zip Code Areas<br>200, 203, 207-208<br>$752.88 per year | Age 70 & under - $701.50 per year<br>71-80 - 778.50 per year<br>81 + 919.00 per year | Age 65-69 - $327.00 per year<br>70-74 - 400.66 per year<br>75-79 - 438.12 per year<br>80 + - 479.76 per year |
| NONE | NONE | NONE | NONE | $15 with application | NONE |
| 6 month waiting period for condition for which medical treatment or advice was rendered in the 1st 6 months before your effective date of policy. No health questions on application. | 6 month waiting period for condition for which medical treatment or advice was rendered in the 1st 6 months before your effective date of policy. No health questions on application. | No waiting period for pre-existing health conditions if fully disclosed in application. | No waiting period for pre-existing health conditions if fully disclosed in application. | 6 month waiting period for condition for which medical advice or treatment was received within 6 months before the policy Effective Date. | 6 month waiting period for any condition for which medical advice or treatment was received within 6 months before the policy date. |
| Pays the Medicare $492 deductible | Pays the Medicare $492 deductible | Pays the Medicare $492 deductible | Pays the Medicare $492 deductible | *Pays the Medicare $492 deductible | Pays the Medicare $492 deductible |
| Pays the Medicare $123 copayment each day | Pays the Medicare $123 copayment each day | Pays the Medicare $123 copayment each day | Pays the Medicare $123 copayment each day | Pays the Medicare $123 copayment each day | Pays the Medicare $123 copayment each day |
| Pays the Medicare $246 copayment each day | Pays the Medicare $246 copayment each day | Pays the Medicare $246 copayment each day | Pays the Medicare $246 copayment each day | Pays the Medicare $246 copayment each day | Pays the Medicare $246 copayment each day |
| Continues at 80% of Eligible Expenses for an additional 365 days in your LIFETIME. | Continues at 80% of Eligible Expenses for an additional 365 days in your LIFETIME. | Continues at 80% of Medicare Eligible Charges for a LIFETIME maximum of 365 days. | Continues at 100% of Medicare Eligible Charges for LIFE if needed. | Continues at 100% of Eligible Expenses for up to an additional 365 days during your LIFETIME. | Continues at 80% of hospital charges for an additional 365 days as your LIFETIME benefits. |
| NOT COVERED | Pays the Medicare copayment of $61.50 per day from the 21st thru the 100th day. | *Pays the Medicare copayment of $61.50 per day from the 21st thru the 365th day. | *Pays the Medicare copayment of $61.50 per day from 21st thru 100th day, and then, $123 per day thru the 365th day. | Pays the Medicare copayment of $61.50 from the 21st thru the 365th day. | *Pays the Medicare copayment of $61.50 per day from the 21st thru the 100th day, and then $20 per day for an additional 100 days if needed |
| NOT COVERED<br>You pay $75 deductible. | Pays the Medicare $75 deductible. | NOT COVERED.<br>You pay $75 deductible | Pays $15 of the Medicare deductible. You pay balance of $60. | *Pays the Medicare $75 deductible. | NOT COVERED<br>You pay the $75 deductible |
| Pays 20% of eligible expenses AFTER YOU PAY $200 OF THE AMOUNT MEDICARE ALLOWS INCLUDING $75 DEDUCTIBLE | *Pays 20% of Medicare allowable charges. | Pays 20% of Medicare Approved Charges up to a $5,000 maximum benefit per ,,ar | **Pays 20% of Medicare Approved Charges and 80% of non-approved charges, after a $50 deductible | Pays 20% of Medicare approved charges for a maximum of $5,000 per calendar year. | Pays 20% of Medicare Allowable Charges for a maximum of $5,000 in a calendar year. |
| NOT COVERED. | NOT COVERED. | NOT COVERED. | **Pays 80% of Reasonable and Customary Charges, after a $50 deductible. | NOT COVERED. | NOT COVERED. |
| May not renew your policy if it does not renew all such policies in your state. | May not renew but must receive prior approval of the Insurance Commissioner. | Guaranteed renewable for life if no misstatements in application. | Guaranteed renewable for life if no misstatements in application. | Guaranteed renewable. | Company reserves right to cancel |
| In-hospital care covered by a daily indemnity of $123 per day for up to 30 days. | In-hospital care covered by a daily indemnity of $123 per day for up to 30 days. | Covered in U.S. only. | Covered in U.S. only. | Coverage same as provided by Medicare. | Optional Rider is available for coverage outside of U.S. |
| | *Optional rider available for 40% benefit. | *Also covers facilities not approved by Medicare. | *Also covers facilities not approved by Medicare.<br>**One $50 deductible covers both benefits. | *Optional Riders available to reduce premiums if you pay the deductibles. | *Also provides coverage in facilities not approved by Medicare. |

5



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| SERVICES | MEDICARE HOSPITAL INSURANCE PART A | MUTUAL OF OMAHA MUTUAL CARE PLUS FORM 9860 -- SERIES 12823 | NATIONAL CASUALTY FORM 9427 RUG | NATIONAL COUNCIL OF SENIOR CITIZENS -- SENTRY INSURANCE EXPANDED PLAN | NEW YORK LIFE FORM 8146--1 |
|---|---|---|---|---|---|
| PREMIUM OR SUBSCRIPTION CHARGES | NO CHARGE - Credited for deductions under the Social Security Program | 65-69 $463 80 per year<br>70-74 573 12 per year<br>75-79 627 96 per year<br>80 + 688 68 per year | AGE MALE FEMALE<br>65-69 $738 $641 per year<br>70-74 857 724 per year<br>75-79 971 814 per year<br>80 + 1,078 897 per year | $558 70 per year | AGE MALE FEMALE<br>65-69 $576 00 $480 40 per year<br>70-74 613 80 501 60 per year<br>75-79 686 40 627 00 per year<br>80-84 732 00 693 00 per year |
| REGISTRATION FEE | NONE | NONE | NONE | Group membership | NONE |
| PRE-EXISTING HEALTH CONDITIONS | NO RESTRICTIONS Covered from 1st day | 6 month waiting period for any condition for which medical advice or treatment was received within 6 months before the policy date | 6 month waiting period for a condition for which you were given medical advice or treatment within 6 months prior to the policy Effective Date | 6 month waiting period for a condition you were given medical diagnosis or treatment within 6 months prior to the effective date. No health questions on application | ACCEPTANCE IS GUARANTEED with 6 month waiting period due to advice or treatment received from physician within 6 months before the policy date |
| DEDUCTIBLE ON ENTRY TO HOSPITAL | You must pay $492 Covers all of hospital costs for 60 days | Pays the Medicare $492 deductible | Pays the Medicare $492 deductible | Pays the Medicare $492 deductible | Pays the Medicare $492 deductible |
| COPAYMENT FOR THE NEXT 30 DAYS | You pay $123 per day. Medicare pays balance of hospital costs. | Pays the Medicare $123 copayment each day | Pays the Medicare $123 copayment each day | Pays the Medicare $123 copayment each day | Pays the Medicare $123 copayment each day |
| COPAYMENT FOR THE NEXT 60 DAYS "LIFETIME RESERVE" | You pay $246 per day. No portion of this period may be used again. | Pays the Medicare $246 copayment each day | Pays the Medicare $246 copayment each day | Pays the Medicare $246 copayment each day | Pays the Medicare $246 copayment each day |
| MAXIMUM PERIOD OF COVERAGE FOR ANY ONE BENEFIT | 90 days plus any unused portion of "Lifetime Reserve" | Continues at 100% of hospital charges for an additional 365 days as your LIFETIME benefits | Continues at 80% of Medicare Eligible Expenses for an additional 365 days as a LIFETIME maximum | Continues at 100% of all Medicare Eligible Expenses up to 365 days in your LIFETIME | Continues at 100% of all covered charges within reason for up to an additional 365 days in your LIFETIME |
| SKILLED NURSING FACILITY | Pays 100% for 1st 20 days with a copayment of $61 50 per day for the next 80 days NO CUSTODIAL CARE!! | Pays 150% ($92 25) of the Medicare copayment each day from the 21st thru the 100th day | Pays the Medicare copayment of $61 50 per day from the 21st thru the 100th day and $123 per day for an additional 365 days in your LIFETIME | Pays the Medicare copayment of $61 50 per day from the 21st thru the 100th day, and then, $100 per day for an additional 265 days if needed | Pays the Medicare copayment of $61 50 per day from the 21st day thru the 100th day |
| MEDICAL COVERAGE FOR PART B | PART B $75 deductible each year Your cost is $15.50 per month | Pays any unpaid portion of $75 deductible if HOSPITAL CONFINED ONLY | NOT COVERED -- You pay the $75 | NOT COVERED You pay the $75 deductible | NOT COVERED -- You pay $75 deductible |
| OUTPATIENT CARE Physician Care for Hospital or Office Services, Surgery, Anesthesia, X-Ray, Laboratory, Injections, Splints, Casts, Dressings, Radiation Therapy, Physical Therapy, Ambulance, Prosthetics, etc. | Pays 80% of reasonable fees and charges | Pays 30% of Medicare Allowable Charges | * Pays 20% of Medicare Eligible Expenses | *Pays 20% of Medicare Eligible Expenses | Pays 20% of ALL CHARGES WITHIN REASON |
| OUTPATIENT PRESCRIPTION DRUGS | Pays 100% as an IN PATIENT ONLY. | NOT COVERED | NOT COVERED | NOT COVERED | NOT COVERED |
| RENEWABILITY OF CONTRACT | Cannot be cancelled | Company reserves right to cancel | Guaranteed renewable for life | May terminate if you give up membership, default premium, give up Medicare, or Group Policy is terminated | Guaranteed renewable |
| TRAVEL RESTRICTIONS OUT OF AREA | Covered in U.S. or possessions. May use Canada or Mexico under certain conditions. See the Medicare Handbook | Optional Rider is available for coverage outside of U.S. | Covers in U.S.A. only | NOT COVERED outside of U.S.A. | Coverage is same as provided by Medicare |
| Medicare & Insurance Supplement Comparison Guide for 1988 for the protective use by Montgomery County, Maryland and prepared by John L. Knowles of Colbourne, | | *Also provide coverage in facilities not approved by Medicare | *Opt.onal plans available to pay 30% or 40% for Part B benefits | *Two optional plans available to provide lower benefits and premium charges | |



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| PRUDENTIAL/AARP SUPPLEMENT PLUS FORM 95-2* | PRUDENTIAL/AARP EXTENDED SUPPLEMENT FORM 95-3* | PRUDENTIAL/AARP COMPREHENSIVE SUPPLEMENT FORM 95-4* | RESERVE LIFE PLAN I FORM GL95/95/04 | RESERVE LIFE PLAN II FORM GL95/95/04 | STATE FARM MUTUAL FORM SP95/96 |
|---|---|---|---|---|---|
| $17.95 per month | $36.25 per month | $66.50 per month | Age 65-69 $ 75.71 $ 888.92 77 (... $ 948.55<br>70- 728.31 72- 888.22 78- 1,092.75<br>67- 750.34 73- 911.56 79- 1,004.59<br>68- 765.85 74- 946.92 80- 1,125.54<br>69- 814.68 75- 971.75 81- 1,163.59<br>70- 842.49 76- 985.67 85- 1,162.35 | Age 65-1,005.45 71-1,338.49 77-1,599.63<br>66-1,116.05 72-1,375.27 78-1,634.42<br>67-1,064.41 73-1,014.55 79-1,688.96<br>68-1,216.87 74-1,464.44 80-1,727.21<br>69-1,254.83 75-1,493.44 84-1,791.88<br>70-1,297.37 76-1,538.75 85-1,897.13 | Age 65-69 $385.50 per year<br>70-74 - 477.70 per year<br>75 + - 572.09 per year |
| Group Membership | Group Membership | Group membership | $30 with application | $30 with application | $10 membership fee |
| 3 month waiting period for any condition for which medical advice or treatment was received within 6 months before policy date | 3 month waiting period for any condition resulting in your receiving medical advice or treatment within 6 months prior to the Effective Date of policy | 3 month waiting period for any condition for which medical advice or treatment was recommended within 6 months before policy date | 180 day waiting period for condition for which medical advice or treatment was recommended within 180 days prior to the effective date of the coverage | 180 day waiting period for condition for which medical advice or treatment was recommended within 180 days prior to the effective date of the coverage. | 6 month waiting period for any condition for which medical advice or treatment was given within a 6 month period preceding the effective date of coverage |
| Pays the Medicare $492 deductible | Pays the Medicare $492 deductible | Pays the Medicare $492 deductible | Pays the Medicare $492 deductible | Pays the Medicare $492 deductible | Pays the Medicare $492 deductible |
| Pays the Medicare $123 copayment each day | Pays the Medicare $123 copayment each day | Pays the Medicare $123 copayment each day | Pays the Medicare $123 copayment each day | Pays the Medicare $123 copayment each day | Pays the Medicare $123 copayment each day |
| Pays the Medicare $246 copayment each day | Pays the Medicare $246 copayment each day | Pays the Medicare $246 copayment each day | Pays the Medicare $246 copayment each day | Pays the Medicare $246 copayment each day | Pays the Medicare $246 copayment each day |
| Continues at 100% of Medicare Eligible Expenses up to 365 days in your LIFETIME. | Continues at 100% of Medicare Eligible Expenses up to 365 days in your LIFETIME. | Continues at 100% of Medicare Eligible Expenses up to 365 days in your LIFETIME. | Continues at 100% of Medicare Eligible Charges for a LIFETIME maximum of 365 days | Continues at 100% of Medicare Eligible Charges for a LIFETIME maximum of 365 days | Continues at 80% of Medicare Eligible Expenses for a LIFETIME benefit of 365 days |
| Pays the Medicare copayment of $61.50 per day from the 21st thru the 100th day, and then, $123 per day thru the 365th day | Pays the Medicare copayment of $61.50 per day from the 21st thru the 100th day, and then, $123 per day thru the 365th day | Pays the Medicare copayment of $61.50 per day from the 21st thru the 100th day, and then $123 per day thru the 365th day | Pays the Medicare copayment of $61.50 per day from the 21st thru the 100th day | Pays the Medicare copayment of $61.50 per day from 21st thru the 100th day, then 50% of daily CHARGE up to a maximum of $10,000 as a LIFETIME benefit. | Pays the Medicare copayment of $61.50 per day from the 21st thru the 100th day |
| NOT COVERED -- YOU PAY THE FIRST $250. | NOT COVERED. You pay the $75 deductible | NOT COVERED -- You pay $75 deductible | Pays the Medicare $75 deductible | Pays the Medicare $75 deductible. | Pays the Medicare $75 deductible |
| Pays 20% of Medicare Eligible Expenses AFTER YOU PAY THE $250 DEDUCTIBLE. | Pays 20% of Medicare Eligible Expenses. | Pays 100% of the usual and prevailing expenses not paid by Medicare | Pays 20% of Medicare Eligible Charges | Pays 20% of Medicare Eligible Charges plus 50% of difference between Eligible Charge and Usual Charge up to $2,500 per calendar year. | Pays 20% of Medicare deductible charges |
| NOT COVERED. | Pays 20% of usual & prevailing expenses after $20 calendar year deductible and for up to $500 each year. | Pays 20% of usual and prevailing expenses after $20 calendar year deductible and for up to $500 each year. | NOT COVERED. | NOT COVERED. | NOT COVERED. |
| Company reserves right to cancel. | Company reserves right to cancel. | Company reserves right to cancel. | Guaranteed renewable. | Guaranteed renewable | Company reserves right to cancel. |
| Pays 80% of reasonable charges for covered expenses up to $25,000 when you pay $50 deductible. | Pays 80% of reasonable charges for covered expenses up to $25,000. You pay $50 deductible. | Pays 80% of reasonable charges for covered expenses up to $25,000. You pay $50 deductible | Coverage is same as provided by Medicare. | Coverage is same as provided by Medicare. | Not covered outside of United States |
| *Other plans available with lower or higher benefits. | *Other plans available with lower or higher benefits. | *Other plans available with lower premiums and benefits. | * $9 annual policy fee, also | *$30 annual policy fee, also. | |



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| SERVICES | MEDICARE HOSPITAL INSURANCE PART A | UNION BANKERS SENIOR HEALTHCARE FORM MH — 18 | UNITED AMERICAN COUNTERPART V-PLUS FORM MAJC + (18) | COLUMBIA MEDICAL PLAN HMO* | GROUP HEALTH ASSOCIATION HMO* |
|---|---|---|---|---|---|
| PREMIUM OR SUBSCRIPTION CHARGES | NO CHARGE - Credited for deductions under the Social Security Program | Age 65-69 — $668.76 per year<br>70-74 — $25...1 per year<br>75-79 — $85.48 per year<br>80+ — $81.45 per year | $725 per year | $52 per month<br>Increases quarterly | $48.56 per month |
| REGISTRATION FEE | NONE | NONE | $10 with application | NONE | $25 with application |
| PRE-EXISTING HEALTH CONDITIONS | NO RESTRICTIONS<br>Covered from 1st day. | 60 day waiting period for any medical conditions that began or were treated within 6 months before the effective date of coverage | 90 day waiting period for which medical treatment or advice was recommended by or received from a physician within 6 months prior to policy effective date | NO WAITING PERIOD after application is approved | NO WAITING PERIOD after application is approved. Acceptance based on applicants health and credit status |
| DEDUCTIBLE ON ENTRY TO HOSPITAL | You must pay $492. Covers all hospital costs for 60 days | Pays the Medicare $492 deductible | Pays the Medicare $492 deductible | COVERED IN FULL | COVERED IN FULL |
| COPAYMENT FOR THE NEXT 30 DAYS | You pay $123 per day. Medicare pays balance of hospital costs | Pays the Medicare $123 copayment each day | Pays the Medicare $123 copayment each day | COVERED IN FULL | COVERED IN FULL |
| COPAYMENT FOR THE NEXT 60 DAYS "LIFETIME RESERVE" | You pay $246 per day. No portion of this period may be used again. | Pays the Medicare $246 copayment each day | Pays the Medicare $246 copayment each day | COVERED IN FULL | COVERED IN FULL |
| MAXIMUM PERIOD OF COVERAGE FOR ANY ONE BENEFIT | 90 days plus any unused portion of "Lifetime Reserve" | Continues at 100% of the Usual and Customary expense charges after Medicare benefit ends. | Continues at 100% after Medicare benefit ends and pays eligible hospital expenses for AS LONG AS CARE IS NEEDED | COVERED IN FULL for as long as needed (except mental health) | COVERED IN FULL for as long as needed |
| SKILLED NURSING FACILITY | Pays 100% for 1st 20 days with a copayment of $61.50 per day for the next 80 days. NO CUSTODIAL CARE!! | *NOT COVERED | Pays the Medicare copayment of $61.50 per day from the 21st day thru the 365th day if needed | COVERED IN FULL WITH NO LIMIT ON NUMBER OF DAYS. | COVERED IN FULL WITH NO LIMIT ON NUMBER OF DAYS |
| MEDICAL COVERAGE FOR PART B | PART B<br>$76 deductible each year. Your cost is $15.50 per month. | Pays the Medicare $75 deductible | *SEE BELOW | COVERED IN FULL | COVERED IN FULL |
| OUTPATIENT CARE<br>Physician Care for Hospital or Office Services, Surgery, Anesthesia, X-Ray, Laboratory, Injections, Splints, Casts, Dressings, Radiation Therapy, Physical Therapy, Ambulance, Prosthetics, etc. | Pays 80% of reasonable fees and charges | *Pays 20% of Medicare allowable charges | *In each calendar year pays half of the 1st $400 of Covered Expenses not paid by Medicare, then pays all additional Covered Expenses incurred up to 140% of the amount approved by Medicare | COVERED IN FULL with co-payment of $4 per visit — $10 per home visit. Includes routine immunizations, eye and hearing exams and periodic health exams. Laboratory and radiology service covered in full | Covered in full except NO SPEECH THERAPY unless part of rehabilitation program; NO ORTHOPEDIC APPLIANCES; NO DURABLE MEDICAL EQUIPMENT; NO BLOOD but does cover administering cost. Does cover routine immunizations |
| OUTPATIENT PRESCRIPTION DRUGS | Pays 100% as an IN PATIENT ONLY | NOT COVERED | NOT COVERED | $4 copayment for prescriptions or refills but must be purchased from a Plan Pharmacy | Covered in full after you pay the first $300 each year |
| RENEWABILITY OF CONTRACT | Cannot be cancelled | Reserves right not to renew | Guaranteed renewable for life | May be disenrolled if a satisfactory relationship cannot be established, failure to pay premiums or consent, or wrong use of | Renewability is automatic |
| TRAVEL RESTRICTIONS OUT OF AREA | Covered in U.S. or possessions. May use Canada or Mexico under certain conditions. (See the Medicare Handbook. | Coverage is same as if provided by Medicare. | Coverage is same as provided by Medicare | World-wide coverage for emergencies only | World-wide coverage for emergencies only |
| * Medicare B Supplement Comparison Guide for 1988 for the exclusive use by Montgomery County, Maryland and prepared by [illegible]. Copyright of California. | [illegible] | *Optional Riders provide partial coverage for Skilled Nursing Facility and increases Part B benefits. | *$200 is the most you pay in any calendar year for Part B | *Evaluating Risk Contract. Columbia HMO is a subsidiary of Blue Cross/Blue Shield. Covers Columbia, portions of MONTGOMERY and other Counties, and portions of Baltimore | *Risk Contract under study. Covers MONTGOMERY, Prince Georges, Howard, ...nd northern Charles Counties to MD, Washington, D.C., and several VA counties. |

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## IV. ABUSES IN THE SALE OF MEDICARE SUPPLEMENTAL INSURANCE TO THE ELDERLY

It comes as no surprise that our Nation's older Americans are the most frequent targets of fraud and abuse in the health insurance marketplace. Their search for health security, as previous sections of this report document, is more intense than that of their younger counterparts. They live in daily fear that a long, drawnout catastrophic illness will strike, and that absent health insurance protection, they will be left bankrupt with little ability to recoup their losses in their retirement years. Their fears are well founded. When seniors do get sick, on the average they are hospitalized about three times as frequently and stay sick three times as long as their younger counterparts. It is this fear seniors have regarding their diminishing health status at a time when the costs associated with health care are increasing that makes them prime targets of health insurance abuses.

Abuses in the sale of health insurance to the elderly have been documented by the Congress, the States, local enforcement authorities and private consumer groups as early as 1965 when the State Special Committee on Aging conducted hearings into frauds against the elderly. In that same year, Medicare was enacted and the conventional wisdom at that time was that there would be no need for health insurance policies to supplement Medicare. As section II of this report suggests, that notion was ill founded. While Medicare was a godsend to senior citizens and literally no one would have it eliminated, seniors were still left paying over 50 percent of their health care bill and for many services like custodial nursing home care and in-home care, dental care and dentures, eye care and eyeglasses, hearing care and hearing aids, foot care, immunizations, routine doctor's visits, and out-of-hospital prescription drugs, and so forth. These gaps in Medicare coverage soon came to be filled by what is known today as Medigap insurance, or Medicare supplemental insurance. With the advent of Medigap insurance came the recognition of abuses in its sale.

The most common abuses noted by regulatory authorities and consumer advocates from 1965 to present include the following:

One: Agents misrepresenting coverage or using brochures which indicate benefits which are not provided by the policy.

Two: Agents recontacting long-time elderly insured and getting them to lapse policies to buy new ones.

Three: Passing the names of elderly, sometimes senile customers, from agent to agent and thus causing the multiple sale of insurance policies.

Four: Agents taking premiums for annual policies and having them issued on a quarterly basis to get large commission.

Five: Agents writing policies on sons, daughters, nephews, and nieces of elderly persons to avoid detection in their sale of duplicate policies.

Six: Agents tearing out riders from policies before delivery to the insured. The riders are generally preexisting condition clauses which exclude payment for various health conditions the insured may possess for a certain time up to 3 years.

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Seven: Agents using high pressure sales tactics or scare tactics to sell the elderly more insurance than they need. Sometimes several agents may visit an old person at the same time to multiply the pressure on the aged to buy insurance.

Eight: Agents forging the signatures of the insured on policies or applications.

All of the above can be done with or without the knowledge and assent of the insurance company, as the 1978 investigation of the House Select Committee on Aging's report, "Abuses in the Sale of Medicare Supplemental Insurance to the Elderly," documented. The report noted, in part:

> The question of whether the insurance company is or should be liable for the abuses—misrepresentation or even fraud—by its agents is among the most troublesome in this field. Certainly one reason that many of the above abuses exist is the fact that many insurance companies pay little commission on renewals. Because of this, there is a great incentive for agents to write new policies which may average 70 percent of the first year's annual premium. Renewal commission may average as low as 5 percent in some companies. The problems are further facilitated by the fact that many insurance companies have chaotic recordkeeping systems and because they do not send out investigators to randomly review the sales their agents are making. It goes without saying that many companies are lax in their screening of agents in the first place.

What follows is a chronology of Federal, State, local, and private efforts relating to abuses in the sale of Medicare supplemental insurance to the elderly; an analysis of responses from State commissioners of insurance confirming abuses in the sale of Medicare supplemental insurance to the elderly (1978 to present); and, a summary of investigations of the House Select Committee on Aging and its Subcommittee on Health and Long-Term Care confirming abuses in the sale of Medicare supplemental insurance to the elderly (1978 to present).

### A. CHRONOLOGY OF PUBLIC AND PRIVATE ACTIVITIES RELATING TO ABUSES IN THE SALE OF MEDICARE SUPPLEMENTAL INSURANCE TO THE ELDERLY

In 1965, the Medicare Program, our Nation's health insurance program for senior citizens, was enacted into law. As noted earlier, the new Medicare Program paid about one-half of the elderly's health care bill annually and seniors were left to insure themselves privately to fill those gaps not filled by the Medicare program.

The Senate Judiciary Committee's Subcommittee on Anti-Trust and Monopoly conducted a series of hearings in the summer of 1972 on the subject of "Commercial Health and Accident Insurance." This hearing record stands as the most detailed Federal evaluation of the health insurance industry following the enactment of the Medicare Program. The hearing focused on a series of questions posed by the chairman of the subcommittee, Senator Philip Hart, and responses from Edmund G. Pabst, executive vice

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president of the Combined Insurance Company of America juxtaposed against those of former Pennsylvania Insurance Commissioner and consumer advocate, Herbert S. Denenberg. The questions, and excerpts of the responses, follow:

QUESTION 1. Are commercial accident and health insurance companies returning a sufficient amount of the (a) individual accident and health insurance; and (b) group accident and health insurance dollar in benefits to their customers?

Mr. PABST. We recognize that in the case of group insurance, the percentage of return can be higher than in the case of individual insurance. In the individual policy field the companies frequently do not have the economies of administration often present in group. Also since individual policies are sold on a person-to-person basis, the selling expense is ordinarily higher than for group.

Mr. DENENBERG. The cost-benefit ratio for many individual contracts is less than 50 percent. Some policies are returning as little as 5 to 10 percent of premiums in benefits to policyholders. Some types of policies, such as the cancer policy, typically return 30 to 40 percent of the premiums in benefits to policyholders.

Individual health insurance companies are burning up about a billion dollars a year in advertising and adminstrative expenses.

The public thinks it's buying medical care. In fact, it's pouring about half its spending on individual contracts into the excessive expenses of the commercial health insurers.

It gets too little protection for the billion that gets burned up in expenses of individual health insurance policies.

QUESTION 2. Should accident and health insurance policies be standardized by regulation?

Mr. PABST. Standardization of health insurance policy forms would not be in the best interest of the public, the providers of health care, or State regulation of the insurance business.

Standardization would stifle competition among insurers, discontinue the incentive for experimentation with new coverages, deter improvements in existing coverage, make it impossible to provide coverage based upon individual need, and would disregard the time tested use of provisions which are based upon the initiative of individual insurers.

Mr. DENENBERG. We would like to see about six standard policies and the disappearance of the gimmick, Mickey Mouse junk, and narrow coverage health policies which now pervade the health insurance market.

The process of standardization should be subject to administrative control and should not be locked into the rigid mold of a statutory prescription. Overly detailed and rigid benefit formula's can destroy the delivery system and make it unresponsive to new delivery methods and new health care technologies.

QUESTION 3. Should health insurance rates be regulated?

Mr. PABST. Accident and health insurance is subject to the jurisdiction of the insurance departments of the 50 States and the District of Columbia. Rates must be filed with most of the State insurance departments and in at least 20 States the departments may disapprove policy forms when benefits are found to be unreasonable in relation to the premium charged. States also review rates to maintain solvency of the insurers. There is a growing tendency on

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the part of the insurance departments to review rates, particularly in the case of increases in premiums.

Mr. DENENBERG. One of our problems is we do not have adequate legislative authority, and it is very difficult to get good insurance legislation. There are a million things that I could talk about.

I spend 4 years revising the insurance laws. I have a stack of insurance laws, but I know what is realistic. I know if I would go to the Legislature and say I want authority to regulate health and life insurance rates, I would never get it.

We have asked for authority to set minimum standards for contracts, and we are having trouble getting it.

You have inadequate insurance laws and it is difficult to get the legislature to act. Unlike Congress, they are often unresponsive.

QUESTION 4. What, if any, overall structural and fiscal changes are necessary to effectuate a system of comprehensive health care and insurance including preventative health care services for all consumers regardless of their financial needs?

Mr. PABST. The industry was not satisfied with a mere statement of policy, even though it was endorsed by all the members of the association. Through its trade associations and through the work of individual companies the industry has done a number of things in recent years to help control its cost.

Mr. DENENBERG. Many of the policies promoted most vigorously include little or no outpatient coverage.

This emphasis on in-hospital coverage has an inflationary impact on the health delivery system. It makes it likely that the policyholder will pressure the doctor to admit for a condition that could be much more economically treated on an outpatient basis.

What is needed is commitment to change and reform by the public, by government, by the providers of health care, and by the insurers of health care. What we need is a partnership between the several States and Washington because all the trust we can bring to bear to solve our problems must be brought to bear—and soon.

QUESTION 5. What has the private health insurance industry done to reduce the ever escalating cost of health care?

Mr. PABST. The industry has also recognized the potential for reducing hospital utilization and the other potential advantages of prepaid group practice plans. The industry has participated in the development and marketing of such programs in Boston, MA; Columbia, MD; and elsewhere.

Mr. DENENBERG. The key to a good health delivery system is control over costs and quality. Without reasonable cost and quality controls money poured into health delivery is merely gobbled up by higher prices.

We have asked the commercial insurance companies to document their cost and quality control measures. On several occasions, we have asked them to testify at our hearings.

Most of the major commercial insurance companies have declined to testify, indicating that they would be represented by the Health Insurance Association of America—HIAA. And the representative of the HIAA has admitted that commercial insurance companies make little or no contribution to effective cost and quality control.

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What this boils down to is that the HIAA has made legislative proposals. It has demonstrated little or no work at cost and quality control.

In 1974, Herbert S. Denenberg, Pennsylvania Insurance Commissioner, released polls showing 81 percent of the public had positive satisfaction with the insurance department and its service. He said that out of 21,000 complaints handled by the department each year, 47 percent related to auto insurance and 30 percent to the sale of health insurance policies.

Writing in "The Progressive," Denenberg described what he called "those health insurance booby traps. . . ." Everyone, of course, is terrified at the prospect of a major illness, but none more than the elderly. Denenberg wrote of "some of the devices that have been widely used by health insurers to mislead the public while making a handsome profit for themselves," including the following which were detailed in the 1978 committee report:

### 1.—They Offer Narrow Coverage but Make It Sound Liberal

A common figure offered as coverage is $50,000. It sounds substantial enough to cover any hospital bill, which is, of course, exactly the impression they want to give. In fact, if premiums are cheap it sounds like a bonanza. Union Fidelity Life Insurance Co. has mastered the bonanza technique.

Headlines scream that the company offers $50,000 in benefits, but what it really offers is about $20 a day if, and only if, you are in a hospital. Stay sick long enough—and in the hospital, not at home and not in a nursing home—and you will undoubtedly collect $50,000. But long enough in this case is about 5 years of continuous hospitalization, a virtual impossibility. So, the company offers the public some breathtaking amount—being sure to give the aggregate figure and not the daily figure.

The insurance company doesn't worry much about the claimant who does require a long hospital stay. Only 2 percent of all hospitalized people stay longer than 30 days, according to the extensive experience of one Blue Cross plan. Union Fidelity's spokesman at our public hearings said the average claim paid by his firm is $174. The largest payout was $10,000.

Another way these companies cut back on seemingly broad coverage is to build in a variety of limitations and restrictions. Denenberg refers to the exclusion for preexisting conditions. And then to cover themselves even more fully, some insurers use another restriction: They do not pay for the following diseases during the first 6 months of coverage: tuberculosis, gall bladder disorders, diabetes, cancer, heart or circulatory disease or disturbance, hernia, sickness resulting from surgery, or disease of the generative organs. (What's left?)

The really clever operator not only can make your coverage sound liberal, but also encourages consumers to

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think they can make a fast buck by being hospitalized. Physician's Mutual Insurance Co. proclaims in bold red headline: "New extra cash plan so practical you may leave the hospital money ahead. Extra cash for sickness! Extra cash for accidents! Extra cash on top of other hospital benefits, even Medicare!"

### 2.—The Companies Make Sure Premiums Are Eaten Up in Expenses and Especially Profits

If the insured gets back more than 50 percent of his premium dollar, the insurance company is, by its standard, being generous relatively speaking. Denenberg reports that the National Liberty Corp. returned after tax profits three times that of blue chips such as American Telephone & Telegraph and the Chase Manhattan Bank. The company returned only 27 cents on each premium dollar and reached profits of up to 46.5 percent on one series of policies.

Mail order policies are intended to supplement regular health insurance, although the fact isn't always made clear in the advertising. Unhappily, a large portion of these policies are held by individuals with no other hospital insurance. Even for people who have basic insurance, extra coverage may be needed, but it should typically be a good major medical policy rather than one of the junk, gimmick policies featured by many mail order insurance companies.

A clever insurance company can establish the ultimate in low return—a dread disease policy that returns only 7 cents on the premium dollar. It would seem that the public would be too smart to fall for such a fraud, but millions of policyholders are paying premiums each year for such policies.

### 3.—The Companies Scare People, Especially the Elderly

The mail order operators prey on the fear of the old people. They suggest to them in the biggest headlines, that they must have health insurance or they will die in the paupers' ward. Or the company reminds them that they certainly don't want to be a burden to their relatives and children. They make them think that their policy can give them enough protection to solve the budget-crunching problems created by illness among retired persons. It doesn't matter to the exploiters that these people will invest a portion of their tiny income in these nearly useless policies. The more important thing to the exploiters is the money; if the policyholders don't understand the fine print, that's tough.

Another effective scare tactic is to push the idea that present coverage is not enough, whatever it is. Hospital costs are skyrocketing, therefore your coverage must be insufficient. The insurance promoters emphasize that they

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provide $50,000 worth of coverage, which should be enough to cover your hospital expenses even in extreme cases. This is an effective technique in promoting policies to supplement Medicare. What promoters don't emphasize is that they pay only a small amount on a daily basis, and then only after the insured pays some of the cost as a deductible and only after they have been in the hospital 6 days under Medicare * * *.

All the mail order companies imply in their advertisements that coverage may not be available tomorrow, so you had better buy today. The tactic works well with health insurance. The fact that they will be offering coverage anew every few weeks is immaterial.

### 4.—The Companies Have Well Known, Trusted Personalities Endorse Their Policies

Among those listed by Denenberg were Art Linkletter for National Liberty Corp., Jack Benny for American Republic Insurance Co. of Des Moines, Paul Harvey for Bankers Life and Casualty, George Fenneman for Continental Casualty Co. Mail order hospital insurance companies are not the only ones which utilized the big name endorsement. Mutual of Omaha, for example, had been using Lawrence Welk to sell coverage. He had been telling his faithful, generally elderly viewers of his national television show the senior security policy of Mutual of Omaha is protection everyone over 64 should have. In Welk's endorsement, two basic principles were combined—the use of the big name personality giving his personal endorsement and the scare tactic. Mutual has now dropped the Welk ad at the request of the Pennsylvania Insurance Department.

### 5.—Mail Order Companies Use Phony Recommendations

Denenberg reports that Union Fidelity and National Liberty have claimed that their company is recommended by Best's Insurance reports. Best's does rate insurance companies for financial stability but says nothing about individual insurance policies. The most advanced form of a phony recommendation was developed by Union Fidelity. It assembled a consumer group whose sole reason for existence was to serve as its front for marketing the company's policies. As a result, Union Fidelity's right to do business was revoked by the District of Columbia in June 6, 1972.

### 6.—Insurance Exploiters Need Political Influence

Denenberg notes that more and more State insurance commissioners have begun to perceive their roles as protecting the consumer, not the insurance industry. The insurance industry, he says, will react by putting pressure on the Governor, in most States the only official who can hold down a conscientious commissioner. He notes that in a few States the insurance commissioner is elected and



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subjected to political pressure, too. Political influence can be generated by loading the insurance company board of directors with as many former Governors and Senators as can be controlled. State legislators are also a good resource for these boards.

Denenberg ended by saying "the whole health insurance business needs a reexamination. The mail order health insurance investigation is only the first skirmish in a major battle against a health insurance system that does not serve the public well." He adds that the insurance industry has a big advantage. There are so many companies each with a myriad of insurance plans. "The biggest asset in the battle is the spotlight of public attention." He says regulation will help and that the goal is to provide the public with an honest representation of the varieties of insurance among which it may choose.

In May 1973, Consumer Reports (CR) published the results of their look into mail order health insurance. CR identified 170 companies which specialized in the sale of mail order health insurance. CR commented that while these companies presently account for only 2 percent of the total health insurance dollars, they are growing at an alarming rate, far greater than other conventional insurance companies.

In summary, whatever promise the concept of mail order health insurance might hold, only a few companies appear to be passing along any mass marketing savings to consumers in the form of a greater return on the premium dollar. Policies are now tied to hospitalization, negating most of the useful purpose they might serve as a form of major medical protection. And the strident advertising claims of large sums of tax free cash clearly attempt to exploit a human desire for big gains on small investments—gains that rarely materialize

Consumer Reports included a separate section on Medicare and mail order insurance:

> Odd as it may seem, the segment of the Americans society with probably the best overall insurance protection for hospitalization is the one most susceptible to the blandishments of the mail order merchants. That, of course, is the Medicare population. Five out of nine of such persons now hold some health insurance protection in addition to Medicare. The elderly are understandably concerned about their health and concerned about the blow a serious illness might be to their limited financial reserves.

The report notes:

> Mail order merchants sell supplementary health policies which are purportedly aimed at the Medicare gaps. One is the standard indemnity coverage—paying a fixed amount based on the number of days a policyholder spends in the hospital. The second is also indemnity but coverage begins only after the 60th hospital day. Neither type directly concerns Medicare's part A, part B or 20 percent copayment provisions. It is also important to note that the indemnity

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policies often pay reduced benefits to persons over age 65 for a number of hospital days, a point not made clear in many ads. National Liberty, for example, pays 70 percent of the advertised indemnity for the first 3 months in the hospital, then 100 percent.

Says Consumer Reports:

> Either type of mail order policy is inadequate to meet the real insurance needs of the Medicare group. The standard indemnity policy may indeed generate "extra cash," as the ads say, for the Medicare recipient who is hospitalized. But it doesn't relate to actual out-of-pocket expenses. Needless to say, with only 0.3 percent of the Medicare population, having a hospital stay exceeding 60 days in 1970, the 60-day deductible supplemental policy is a guaranteed moneymaker for the companies.

In December of 1974, the Senate Special Committee on Aging released an issue paper prepared by Gladys Ellenbogen entitled "Private Health Insurance Supplementary to Medicare." The report is based on interviews with State insurance commissioners in five States: California, Florida, Pennsylvania, Nevada, and Arizona. The introduction to the report says the five States represent 16 percent of the population over age 65 and include the top three States in terms of rate of growth of the aged population. "it is not a nationwide survey of State departments of insurance. On the other hand, it is hoped that its usefulness transcends the number of States chosen."

This report stood for years as the most detailed look at health insurance policies that supplement Medicare. The report concluded:

> Our consultations with departments of insurance in some States indicate there exists a common set of problems concerning private health insurance for the aged.
>
> Insurance departments consider the following to be among the major problems encountered by the elderly in their purchase of private health insurance: duplication of coverage, policies specifying flat dollar amount of payments without regard to rising health care costs, long waiting periods before the effective date on which the policy's protection begins, long preexisting condition periods and misleading advertising in the offering of policies.

The Senate report also mentions the selling tactics of some unscrupulous insurance agents:

> On this subject two particularly unfortunate practices are overinsurance and unwise cancellation of a policy with the simultaneous purchase of a new policy from the same agent.

On September 25, 1974, William J. Sheppard, then Pennsylvania Insurance Commissioner, announced an intense crackdown on insurance companies and their agents who have engaged in the disgraceful exploitation of the senior citizens of Pennsylvania through the sale of health insurance. He said that agents were revisiting

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old customers and replacing existing policies, that they were passing around names of victims and thus causing multiple sales, that they were writing policies under a variety of names, that is Mary Smith, Mary A. Smith, M. Ann Smith to avoid detection of the multiple sales. He said they were writing policies on sons, daughters, nephews and nieces of the elderly and sometimes forging the signatures of applicants.

Commissioner Sheppard reported that 27 percent of the people reporting common health insurance abuses were senior citizens. He said that a severe problem existed in the Greater Pittsburgh area and announced the opening of several complaint centers to make sure that senior citizens are not taken advantage of by unscrupulous business tactics or agents.

The commissioner announced the results of his investigation in an October 31, 1974, speech before a group of senior citizens in Pittsburgh. He said the most shocking case involved an 80-year-old woman from Meadville, PA, who had spent $50,574 on 31 policies over a 3-year period, all of which had lapsed. Sheppard said the women's savings were wiped out and she even took out a $3,000 loan from her bank to make further payments. Sheppard contacted the presidents of the nine insurance companies involved and was able to get six companies to refund a total of $30,000 to the woman.

Many insurance agents are contacting elderly citizens and selling unnecessary policies, said the commissioner. Other folks are being encouraged to cancel their health insurance to buy new policies and thereby lose coverage for sicknesses they are fighting. Still other agents represent themselves as being from the Social Security Administration and then sell unnecessary commercial policies.

A special problem in the Greater Pittsburgh area is that disreputable agents had been inducing elderly citizens to believe purchases of life insurance policies with annuity riders are investments similar to mutual funds. Elderly consumers are encouraged to draw their life savings from the bank to make these purchases. They are erroneously led to believe that all their money may be refunded at any time the request is made.

Finally, some insurance companies deliberately stall payment of claims presented by senior citizens. We saw an elderly Indiana woman forced to go on welfare because an insurance company refused to pay her disability claim. Only after our intervention did the insurance company begin to pay what this 67-year-old woman was owed.

Commissioner Sheppard stated that there are several causes of the problem. First, the companies involved have been very lax in screening the type of agent they hire. We find many of these problem agents go from one such company to another, lapsing and rewriting their client's health insurance as they go. These companies only seem to care about placing new business on their books. Second, life-health insurance companies pay very little commission on renewals. Thus, there is an incentive for the unscrupulous agent to rewrite policies. Additionally, some of these companies pay a higher commission for shorter term policy.

The results of the investigations in Pennsylvania were far-reaching. The Department had investigated 24 companies it suspected of

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violating law and regulations. At least 6 of the 24 companies were found to have posed serious problems for the elderly. Ten agents were indicted for criminal conduct such as fraud or forgery. Many more lost their licenses or their jobs. Hundreds of thousands of dollars were returned to the senior citizens who have been victimized. Moreover, some changes were implemented in the Pennsylvania regulations. However, for all the progress, Commissioner Sheppard reported on August 27, 1975, that health insurance complaints, although reduced in number, still ranked second in that State only to automobile insurance. He said the department handled about 20,000 complaints in the previous year relating to all kinds of insurance. Upon investigation, 46.9 percent of the claims were found to be valid.

In 1976, Consumer Reports (CR) published a report on "Health Insurance for Older People: Filing the Gaps in Medicare." The report included a useful line-by-line comparison of several Medicare supplemental insurance policies.

Consumer Reports also highlighted the techniques used by agents to victimize older insurance buyers and points out that the problem may not always be the unscrupulous agent but the careless insurance company. An example was provided of an insurance company whose certificates for coverage on two policies called for less extensive hospital coverage than was promised in the company's brochures.

While ranking 16 typical Medicare supplemental policies with CR felt were fairly typical, CR cautions, "None of tne 16 covers all the medical expenses an older person might expect to occur. Nor will a combination of policies do the job. Yet older people often buy several policies, hoping to fill as many of Medicare's gaps as possible. This is understandable but expensive."

By way of recommendations, Consumer Reports suggested enrolling in a pre-paid health insurance plan otherwise known as a Health Maintenance Organization (HMO), adding that few HMO's are available and fewer still accept new patients over 65.

In early 1976, Oregon Gray Panthers working with the Legal Services Developer for the Elderly for the State of Oregon, Ron Wyden (now Congressman Ron Wyden, D-Oregon) began to agitate for regulations that would require each agent to advise the elderly (by giving them a chart) specifically what is and what is not covered by Medicare and to describe by this same method what gaps would be filled by the proposed policy to be purchased.

Their request was initially rebuffed by the State insurance commissioner, who said he had no authority to require companies to use such charts. However, hearings were called for September 1, 1976, and were attended by over 400 senior citizens.

According to Ron Wyden, 30 seniors testified at the all-day hearing on behalf of adopting the rules. Most persuasive testimony came from several retired insurance salesman and 86-year-old Grace Lapray of Salem, who was asked why she purchased four different policies with identical coverage from the same agent. He said, "Trust me," she explained.

In December of 1976, the Commissioner filed new regulations which required insurance agents to use a chart specifically showing Medicare's gaps and how they would be affected by any policy.

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Comments Wyden, "Oregon's senior activists had won a major reform. No other State has yet provided the elderly with such a valuable reference tool to help with the purchase of supplementary medical insurance."

In Ohio, on November 1, 1977, Cilla Bosnak, a writer with the Dayton Journal Herald wrote about abuses in the sale of Medicare supplementary policies as discovered by Ohio Better Business Bureau director, Hazel Nolan:

> Illness and insurance agents both prey upon the elderly—sometimes at the same time * * * Older people are highly vulnerable both to illnesses and to misleading sales pitches. And they are easy targets for crafty agents or companies using "scare tactics" or misleading figures to sell insurance to clients already frightened by high hospital bills.

Bosnak reports that a questionable solicitation surfaced when someone complained to the Better Business Bureau about an apparent insurance solicitation through the mail.

You couldn't be sure it was insurance, however, because neither the company nor its address was included on the booklets—"A Pocket Guide to Medicare." And some of the literature bore a remarkable resemblance to a government Medicare publication.

Better Business Bureau Director Hazel Nolan said, "There is nothing to indicate this is an insurance agency. Nowhere does it talk about insurance. All it talks about is Medicare."

She said the insurance pitch used Medicare data and underscores the shortcomings of Medicare. "They scare the elderly to death," said Nolan. "This is one of the more horrible examples."

After a 2½-year investigation, marked by frustration trying to cope with abuses in the sale of Medigap policies, former Wisconsin Insurance Commissioner Harold Wilde gave a scathing speech calling for Government action to end what he called the "Medi-scare insurance racket, a multimillion dollar ripoff of our senior citizens." His speech is a landmark in this area and deserves to be quoted at length. In his preface, he hastened to point out that he was not criticizing all insurance companies or condemning all sales of supplemental policies to the aged. Excerpts follow:

> If I were to talk to you today about a multimillion dollar racket, that has swindled tens of thousands of Wisconsinites over the past few years—many of them poor or on fixed incomes—and were to add that, to my knowledge, none of the ringleaders in this racket has yet gone to jail, and some are still making hundreds of thousands of dollars a year at it—what would be your reaction? Anger? Outrage? Disbelief?
>
> Well that is precisely what I am going to do.
>
> The racket is the sale of ripoff insurance to people over age 65—the sale of what I call Medi-scare insurance.

The Commissioner added:

> We have greatly strengthened our enforcement efforts. We have increased the number of agent license revocations and suspensions from a handful in 1974 to 70 thus

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far in 1977 alone. We have fined one company $25,000 and suspended it from the market for over a year. We have distributed over 15,000 of our booklets to senior citizens outlining their health insurance needs and rights. But the problem does not go away.

As a State insurance commissioner, I am wary of Federal insurance regulation. But this is a nationwide problem, created in part by a Federal program. I believe that—in the absence of a concerted national effort by the insurance industry—Federal action will be required to clean it up.

In Wisconsin, we are attempting to do all that we can do at the State level.

As part of their continuing surveillance of Medicare supplemental policies, the State of California brought legal action to revoke the licenses of two insurance salesmen, Donald B. Lee and Frances Dougherty in January of 1978.

The action against Lee contains numerous charges including the following as quoted from the legal documents filed in the case by then State Insurance Commissioner Wesley J. Kinder:

1. That Lee took an application from Gertrude Barsi and received a check from her in the amount of $133.64 which represented the premium on a nursing home policy to be issued on Mrs. Barsi's husband by Constitution Life Insurance Co. However, Lee failed to forward such application and the premium to Constitution, thereby exposing Barsi to the risk of loss and further failed to refund the premium until several months later when contacted by the State Commissioner of Insurance.

2. That Michael Kesslar, one of Lee's employees, took an application and received a check drawn by Ina Bellinger in the amount of $173.45 for a health policy. The check was deposited in Lee's trustee bank account. Lee did not send the premium and the policy to the insurer and thereby exposed Bellinger to the risk of loss. He failed to refund the premium until 6 months later when contacted by the State Insurance Commissioner.

3. That Lee induced William French to purchase two policies from Constitution Life Insurance Co., by falsely representing that thousands of policies of Blue Cross, their present employer, were either arbitrarily cancelled or having restriction added. Relying on these representations, French gave a check of $193.58 to Lee. Lee knew or should have known that the representations were false in that Blue Cross of Northern California was not arbitrarily cancelling or restricting health insurance policies. Lee's employee, Douglas Patricks, delivered the two policies to French and collected $71.51 from him as premium balance due and advised French to discontinue his existing Blue Cross insurance, which provided medical, surgical, and hospital benefits, because the Constitution Life policy also covered these expenses. Patricks, however, misrepresented the facts because the Constitution Life policy specifically excluded benefits for medical and surgical services rendered by a physician or surgeon. Moreover, Lee aided and abetted his employees Douglas Patricks and Michael Kesslar * * * to solicit in-

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surance when he knew that they were unlicensed in the State of California. Lee signed the receipts and applications made by Patricks and Kesslar and appeared as the agent of record knowing that signing for sales made by others who are unlicensed is a violation of California law.

Unfortunately, Lee *et al.*, failed to obtain health insurance promised for many of the 39 individuals, thereby exposing them to risk of loss. They also failed to refund the money they collected.

With respect to Frances Dougherty, the commissioner found the following:

1. That she had received a $265.35 check from Fae Baldwin representing the premium on a health insurance policy from Globe Life. Instead of purchasing a policy or returning the money, she diverted and appropriated said funds to her personal use in violation of the California Insurance Code.

2. That she had received a check in the amount of $291.50 from G.B. Hylton representing the premium on a health insurance policy from United Insurance Co. obtained from Hylton's wife. The name of the payee was left blank on the check with the understanding that Dougherty would stamp in the name of the company. Dougherty made the check payable to herself, endorsed and cashed the check. She neither returned the money to Hylton nor obtained the requested policy for him.

3. That she induced Vera Gearing to purchase a hospital indemnity policy and a medical and surgical policy by falsely representing that both policies would cover the preexisting condition of her leg if Gearing paid an extra month's premium in advance on each policy. Relying on the representation that her leg condition would be covered, Gearing entered the hospital for treatment of the preexisting condition in her leg. The insurance company refused to pay and Gearing subsequently cancelled the policies. Dougherty either knew or should have known that preexisting conditions would not be covered. Obviously, this misrepresentation resulted in Gearing's not having any insurance coverage.

In summary, the commissioner concluded that Dougherty had "knowingly misrepresented the terms or effect of insurance policies for the purpose of inducing * * * the purchase of a policy of insurance * * * engaged in fraudulent practice and conducting her business in a dishonest manner; failed to perform duties required by the insurance laws of the State; offered to pay or paid unlawful rebates." Accordingly, the commissioner declared that it would be against the public interest to permit Dougherty to continue transacting insurance in the State of California.

These are but two of the case histories handled by the California Department of Insurance which has one of the most aggressive enforcement records in the Nation with respect to protecting senior citizens from insurance ripoffs.

In March 1978, a lawsuit was brought by several members of the American Association of Retired Persons (AARP) on behalf of all such members in the State of New York. The suit alleged that AARP is under the domination and control of the Colonial Penn Insurance Co., and that in essence AARP and its sister the Nation-

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al Retired Teachers Association (NRTA) which together boast 11 million senior citizens as members, are fronts which the insurance company uses to increase its profits.

Instead of paying salesmen commissions, the suit alleged, Colonial Penn yearly made a several million dollar contribution to AARP/NRTA in the form of administrative expenses. The infusion of millions of dollars enables the association to keep its membership fees low—currently $3 a year for a person or a couple.

The lawsuit alleged that Colonial Penn has custody of the AARP/NRTA mailing lists—that no other insurance company was given either access to these lists or was permitted to advertise in NRTA/AARP publications, such as the magazine, Modern Maturity.

The suit charged that AARP policies were a bad buy because they paid indemnity benefits and returned only 62 percent of the premium dollar in claims as compared with 91 percent in the case of commercial insurers selling group policies.

The U.S. Postal Service has closed its investigation, having failed to find any evidence of inpropriety. In addition, AARP also points to a recent IRS ruling upholding our nonprofit tax exempt status as affirming the propriety of the relationship with Colonial Penn. The suits brought by New York AARP members and by Harriet Miller are pending.

During the last week of February 1978, the Newark Star Ledger ran an important special report which exposed abuses in the sale and regulation of Medicare supplemental insurance policies in the State of New Jersey. The articles by reporter Herb Jaffee began:

> More than half a billion dollars a year are paid by Jerseyans for health insurance policies that are neither regulated, carefully scrutinized by the State nor formally approved by the insurance commissioner.
>
> In some cases, these policies and their fine print and vague disclosures of benefits sold by agents of commercial insurance companies are designed to deceive and exploit unwary policyholders.
>
> Instances of relatively useless health insurance policies for which consumers have paid annual premiums ranging into several hundreds of dollars have been discovered by the Star-Ledger.

Jaffee charged that many policies sold to senior citizens had little economic value in reality. He reported that some companies encouraged unethical practices on the part of their agents. He quoted New Jersey officials as saying they couldn't remember the last time an insurance agent's license was revoked in connection with the sale of health insurance.

The recent interest in Medicare supplemental insurance policies was greatly fueled earlier this year by 2 days of hearings conducted by the Senate Special Committee on Aging. Senator Lawton Chiles chaired the Senate hearings. From the very first, the hearing produced shocking revelations.

Robert E. Lowry testified that his 76-year-old mother bought 13 different life and health insurance policies from seven agents during a 2-year period, even though the policies cost her more than

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$9,000 a year or 68 percent of her annual income. Mr. William Grubb, a vice president for Bankers Life and Casualty (which the seven agents represented) told the committee that Mrs. Lowry's case was not typical. "Frankly, we're embarrassed," he said. He added it is difficult for a large company to control the activities of all its agents and that the unscupulous agent in this case had been forced to resign.

W.W. Cooper, former administrator of the Florida Insurance Department, entered in the record a similar letter sent by an elderly couple, ages 82 and 78, who delayed repairing their refrigerator, television, or stove because they were trying to keep up a $2,882 annual premium on 19 separate insurance policies. Cooper said that the problem in Florida was under control and that most of the unscrupulous agents had been driven out of the State.

Another example related at the hearing concerned a 79-year-old farmer from Ohio who had been told by one salesman that the Federal Medicare program was broke as a justification for selling the man more insurance, allegedly to protect him against catastrophic illness.

Jules Klowden, an insurance consultant with a San Diego, CA, senior citizen center described many Medicare supplemental insurance policies as junk policies which offer no benefits (but) can bankrupt a family.

After the first day of hearings, the members of the committee were greatly distressed. Senator John Glenn talked about the abuses in terms of the economic rape of the elderly. "This has got to be a real flimflam—a real fraud situation," he said. Ranking minority member on the committee, Senator Pete V. Domenici, said, "The elderly are becoming a new and expanding market for the unscrupulous. Senior citizens are often lonely and want someone to talk to (and) insurance agents know this."

Former Wisconsin Insurance Commissioner Harold Wilde provided the committee with testimony in the form of a summary of his December 1977 speech. He also provided the committee with its best suggestions for reform. He said he was generally wary of Federal intrusion but welcomed Federal interest here because "there is a Federal moral responsibility" and for "practical reasons." He said the Federal Government created the Medicare Program and its gaps and the problems left in its wake.

Weekly Review is an independent newspaper for senior citizens in the Chicago area. During early June of 1978, they published an investigative piece under the byline of Editor J. Ram Ray. The newspaper expose focused on Medicare supplemental insurance ripoffs.

In July 1978, Kansas Insurance Commissioner Fletcher Bell discovered serious abuses in the sale of Medicare supplemental policies in his State, so much so that he called together the companies specializing in such sales in the State and warned them not to continue preying on the elderly. Among the cases turned up in what Bell called his preliminary investigation were the following:

> An elderly woman was sold 11 policies by one company in the last 3 years with three currently in force. Total premium payments over the period were in excess of $2,500.

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Bell said that some Kansas residents have been sold as many as two dozen policies providing unneeded or duplicative coverage. He said that many senior citizens are victims of loading and switching. The sales of multiple policies to one person is called loading, he said, while switching is the practice of lapsing an existing policy and the sale of a new one because the agent receives a substantially larger commission on the sale of the new policy than on the renewal of the existing policy.

As a result of the investigation, one company was fined $5,000 and five agents were brought forward on license revocations.

As summarized in the Los Angeles Times, the 1978 FTC report said that one quarter of the elderly Americans who annually spend $1 billion for extra insurance to cover Medicare gaps actually buy unnecessary, costly and overlapping coverage.

The report said that lack of consumer information, unscrupulous sales tactics by some firms and a lack of uniformity in policies had created considerable confusion among consumers and caused higher health costs for elderly persons living on fixed incomes. The report also picked up on Commissioner Wilde's suggestion that the Federal government must address the problem since the problem had its genesis in the enactment of Medicare in 1965.

Commenting on the FTC report, Congressman James Florio, a member of the House Aging Committee, said, "The elderly are ripe victims of unscrupulous insurance salesmen. Since the advent of Medicare, an apparent need has developed to cover what Medicare does not. However, we did not foresee the potential for health insurance fraud that occurred as a result of this gap in coverage."

On July 19, 1978, Congressman Claude Pepper wrote to the Postmaster General of the United States asking for any further experience with insurance fraud and abuse in the files of the Postal Service. Listed below are typical or current cases involving alleged mail fraud in the sale of insurance. The Postal Department commented:

> Elderly persons in many cases tend to be timid and trusting, to be unsophisticated in the ways of confidence men, and to be vulnerable to the blandishments and high pressure tactics of dishonest promoters. It is an unfortunate fact, and a commentary on the heartlessness of these fraudulent operators, that an elderly person once victimized derives no immunity thereby from further exploitation. He or she may well be added to a list of proven easy marks to be targeted again by the same fraudulent operator or his associates.
>
> Our investigations are initiated in the usual case upon receipt of complaints from victims of an ongoing scheme. For the person who has already been defrauded, investigation and prosecution of the operators of the scheme are after-the-fact events unlikely to benefit him personally. Restitution of the money lost is improbable. Closing down the operation and prosecuting the operators does, however, assure that others will not be victimized by the same scheme.

The Chicago Tribune Task Force published a hard-hitting series on the problems of the elderly beginning the third week of Septem-

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ber 1978. One segment of the series which was especially powerful was headlined, "Insurance Firms that Feast on the Fears of the Aged." In the course of preparing the report, Tribune reporter Bill Gaines worked as a trainee with insurance companies in Tennessee and Illinois. In using this technique, Gaines was able to obtain firsthand information on the operations of several companies that specialize in the sale of Medicare supplemental policies. He found some companies and their salesmen scrupuluously honest. Others were less so.

In addition to posing as a trainee with insurance firms, Gaines examined records which showed that some insurance companies are returning less than 30 cents on the premium dollar in benefits for health insurance.

The Tribune reported that records in the Tennessee Department of Insurance shows that only 22.7 cents of each dollar a person that State pays for accident and health insurance is returned in benefits by the company.

The Tribune reported that Gaines later took a trainee position with an agency whose agents traveled from town to town in rural Illinois working out of motels. They got leads on prospective customers from the Illinois Association of Senior Citizens, a not-for-profit corporation with 30,000 members that operated from a basement office in Peoria.

The Tribune reported that, "Last year * * * the insurance company Gaines worked for * * * paid more in commissions to salesmen than in benefits to policyholders according to official reports filed with the Illinois Department of Insurance: 37 cents on the dollar to policyholders and 38.2 cents to salesmen.

In November 1978, the House Select Committee on Aging, chaired by Congressman Claude Pepper (D-Fla.), held hearings and released an exhaustive report entitled "Abuses in the Sale of Medicare Supplemental Insurance to the Elderly in Supplementation of Medicare: A National Scandal." The committee called the problem a national scandal of staggering dimensions. Testimony revealed that some insurance companies and their unscrupulous agents had become merchants of fear. "Capitalizing on the anxiety about ever-escalating health costs, they have conspired to sell senior citizens multiple, unneeded, duplicative and therefore, essentially worthless insurance policies in supplementation of Medicare, the national health insurance program for the elderly."

A 444-page committee report, "Abuses in the Sale of Health Insurance to the Elderly: A National Scandal," estimated that senior citizens were being taken for as much as $1 billion out of the $4 billion they spent for Medicare supplemental policies each year.

The committee found that it was not uncommon for senior citizens to have 3, 5, 10, 30 and in one instance 91 different insurance policies. In the most blatant example to come to the committee's attention, a 76-year-old Illinois woman paid over $50,000 in insurance premiums over 10 years and was forced to remortgage her farm to keep up with the premiums.

Both the 1978 hearing and its study zeroed in on the pervasive abuse in insurance policies that claim to supplement Medicare. The study was the first detailed national investigation of this problem. It represented the first time that every State department of insur-

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ance and the great majority of companies selling Medicare supplemental insurance policies to the elderly had been surveyed. For the first time, large numbers of senior citizens had been asked about their problems with such policies. In addition, the committee conducted investigations in nine States and the District of Columbia:

For example, Margaret Dickson, one of the committee's senior citizen investigators, got some unsettling advice from health insurance agents when she asked them to look over her collection of supplementary policies for Medicare.

Mrs. Dickson was overinsured, but most agents insisted that she buy even more coverage. Some dismissed her policies as garbage without even looking at them, and pressed her to replace them with as many as eight new overlapping plans. Mrs. Dickson said one agent grilled her about my tax bracket, my banks, my general financial situation, and then suggested—oh heavens, I cannot say it—euthanasia as a solution to long-term health problems. He also asked her to give him power of attorney over her affairs.

What these agents didn't know was that Mrs. Dickson, a retired receptionist for the committee chairman, was working with congressional investigators. Her son, who took photographs of the meetings, and the insurance sales trainee sitting in on them were committee investigators.

In 50 such inteviews, conducted during the fall of 1978, only eight agents honestly advised, "Gee lady, I think you've already got too much insurance."

Mrs. Dickson's case was not unique. Investigators found widespread misrepresentation of what policies pay for, high-pressure sales tactics, agents posing as Federal employees, agents persuading elderly persons to replace adequate policies with new ones just so the agent could get a higher commission, and companies that paid out very little in benefits compared to the large amounts they collect in premiums.

In addition, the report detailed the activities of four staff investigators who obtained jobs with insurance companies in order to determine whether the abusive marketing practices were company policy.

A 1978 study by Chairman Claude Pepper, House Select Committee on Aging, concluded that there were widespread abuses with respect to so-called Medigap insurance policies and the manner in which they were sold to the elderly. It also concluded that there has been failure to aggressively regulate such abuses by many State Insurance Commissioners. The study likewise concluded that most major insurance companies are not involved in the abuses which filled the report.

The abuses that were found were among the insurance companies who specialized primarily in the sale of individual policies. Even then, the most serious problems were generally found among the small and almost anonymous insurance companies that specialize in selling to the elderly.

Following the investigations and hearing by the House Select Committee on Aging, Chairman Claude Pepper introduced H.R. 2602, a bill to curb the proliferation of abuse in the sale of Medigap insurance. The bill, which enjoyed the cosponsorship of 265 Members of Congress, would:

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Establish a program of voluntary certification whereby these policies which meet or exceed Federal minimum standards could be awarded a Federal seal of approval by the Secretary of Health, Education and Welfare.

Make it unlawful for insurance agents to indulge in two common abuses: overselling and the government look. There were no laws prohibiting an agent from deliberately selling seniors more insurance than they need or pretending to be representing the Federal Government or from using advertising materials displaying the Federal eagle and giving the appearance of an official Government document. These practices would be outlawed under the bill.

Help the States regulate mail order insurance. Under current law in 1977, the States could not effectively regulate Medicare supplemental insurance sold through the mail. The proposal would require mail order Medigap firms to first file their policies with the commissioner of insurance in the State in which it would be sold and obtain his or her approval before they could mail their policies into that State.

The introduction of H.R. 2602 stirred up a strong lobbying effort against its enactment by opponents in the insurance industry. Even with strong bipartisan support for the reform legislation in the House, efforts to move the bill swiftly through the House were stalled by intensive lobbying forces. Staff of the House Select Committee on Aging met with staff of Senator Max Baucus (D-Mont.) and then Senator John Culver (D-Iowa) to seek support for movement of the bill in the Senate. Both Senators agreed to introduce S. 1295, a bill identical to Chairman Pepper's H.R. 2602. Between December 5, 1979 and January 30, 1980, Baucus redrafted his bill to exempt from the certification program health insurance contract established by employers or labor organizations. Baucus also went along with an amendment making clear that effective State programs could replace Federal certification.

The Baucus bill had strong political appeal and was adopted as an amendment to a Social Security disability bill approved by the Senate on January 30, 1980. The House passed its version of the Baucus amendment May 22, 1980. And, on June 9, 1980, the voluntary certification of Medicare supplemental health insurance policies became Public Law 96-265. Among other things, the new law required that a program of voluntary certification for Medigap policies be established; the overselling and the government look as insurance practices be outlawed; that mail order firms be required to first file their policies with the commissioner of insurance in the State in which the policy is sold; and that a study of State regulation of such insurance be undertaken by the Department of Health and Human Services.

On January 15, 1979, Business Week, noting that heart disease kills far more people than cancer, stated that there is tremendous fear of cancer in American society. It continues:

> Cashing in on this fear is the obscure but increasingly controversial American Family Life Assurance Co. of Columbus, GA, which 15 years ago became the Nation's first marketer of insurance policies that cover the expenses of

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treating cancer. Even though as many as 300 insurance companies—mostly smaller ones—offer similar coverage, 60 percent of all cancer policies in force have been written by American Family.

With the company's success in cancer insurance has come a measure of notoriety. Increasingly, critics both within the industry and outside the insurance fraternity, such as State regulators, consumer groups, and even representatives of the National Cancer Foundation, are damming cancer insurance. These opponents argue that it is little more than a mercenary exploitation of public fear, and that it is a bad buy, offering only paltry benefits for the cost.

Most of the country's big life insurance companies, which as a rule also offer accident and health programs, do not sell cancer policies. These insurers contend that people are better off under a more comprehensive health plan covering all other diseases and cancer. "If a person buys cancer insurance, he's only partially covered," says Alan N. Ferguson, vice president and actuary for Prudential Insurance Co. of America. "It's like insuring only part of your house against fire."

Far harsher was the condemnation by one executive with a major insurance company, who declares: "American Family is selling garbage. And they're making a lot of money on it. Their appeal is to the fears of people—pure and simple."

Business Week added:

> Some State insurance watchdogs charge that another key to the success and profitability of the cancer marketers is that too little is paid out in benefits. "When you end up with multiple policies, you're usually paying what amounts to duplicate premiums for too little coverage," says Peter Kelly, director of financial and regulated affairs for the Connecticut Insurance Department.
>
> "I have never seen a specific disease policy with a high loss-ratio (benefits paid related to premiums collected)," says one state insurance commissioner. "I am deeply concerned about cancer insurance, because I believe it is sold by people improperly using high-pressure tactics without sufficient disclosure about the product."

A June 11, 1979 Washington Post article entitled "Cancer Insurance Coming Under Increasing Attack" contained the following:

> Barely 7 weeks after the nuclear accident at Three Miles Island powerplant, Mutual of Omaha began an intensive sales campaign in the Harrisburg, PA area for what has become one of its hottest selling products: cancer insurance.
>
> You kind of hate to capitalize on something like that says a Mutual sales manager in Harrisburg, who nonetheless confirms that his agents went door to door warning

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residents there that they may risk cancer because of radiation that leaked from the powerplant.

During a June 13, 1979, hearing by the Subcommittee on Health and the Environment, House Committee on Interstate and Foreign Commerce, Congressman Claude Pepper, chairman of the House Select Committee on Aging, testified about his bill, the Senior Health Insurance Reform Act of 1979.

At that hearing, a colloquy took place between Chairman Pepper and Congressman Andrew Maguire. Congressman Maguire said:

> I have one other question about cancer policies. I notice that you have gone into that in the staff study, particular with some work in the State of Maryland, and I note that New Jersey is one of three States that has legislated against cancer policies or other dread disease policies, which really are another way of victimizing people and preying on their fears and their suffering, because these policies, like the one you described for Medigap coverage, simply do not do the job. People pay enormous amounts of money for almost no coverage that would ever be available to them, or if they got cancer, that would give them any coverage that was worth talking about * * *. I am just wondering if we need to do something additional. What does the bill do now about the dread disease policies, the cancer policies, which are not being sold, I understand, to people in the Harrisburg area after the nuclear accident there, door to door? They are selling these people policies which they think will somehow protect them against cancer or pay for cancer if they get it. Of course, neither of these things is true.

Chairman Pepper answered:

> We are in a dilemma—those of us who want to protect these people are in a dilemma. Heretofore, Congress has enacted legislation against Federal Government regulation of insurance company operations on the theory that it is a matter that ought to be handled by the State. Now we find a flagrant lack of action of the proper character by the State, so we are looking around. What do we do? Do we reverse our previous abnegation of authority that we could assert, of the Federal Government regulating insurance, having to grant licenses, revoke licenses, police the operations of these companies and all that?
>
> Or do we just do sort of the best we can to try to exert a wholesome Federal influence?
>
> This bill is a very minor step in the right direction; at least it offers a hope that there will be some persuasive leadership given by the Federal Government to the States.
>
> Your distinguished committee, if it were to approve this legislation, I am sure would have language in a report that would encourage the State to take the prime responsibility for that matter. This is a mild and a very timid beginning, but it is a beginning, and it does tend to protect people.

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> Take these cancer policies. I can't believe that the Department of HEW would approve these cancer policies that we have had presented to our committee. We intend, of course, that cancer policies be included in our bill.

On June 17, 1979, the Philadelphia Bulletin ran a story by Stephen Franklin which described new State regulations which took effect on July 24 requiring insurance firms to provide minimum coverage benefits. The effect of these regulations is to strongly discourage the marketing of cancer insurance. The report began:

> It's a sales pitch fed by fear and uncertainty.
>
> If cancer strikes, where will you get the money you'll need for hospitalization * * * radium, cobalt, chemotherapy (drug treatment) or x-ray therapy asked an advertisement placed in 12 Pennsylvania newspaper last week by a King of Prussia insurance firm.
>
> Don't be one of those who refuse to face the frightening facts of cancer, warned the ad from World Life and Health Insurance Co.

The article continued:

> On the surface, cancer insurance has appeal.
>
> It is cheap, generally costing between $50 and $150 a year. It is usually easy to get, and most companies selling it promise to pay the steep medical bills associated with cancer treatment.
>
> But not everyone considers it a bargain. Its critics, including some State and Federal officials, have wondered if it is any better protection against the high costs of cancer than an umbrella against a hurricane.
>
> They say the policies, often sold through fear or high pressure sales tactics, are close to worthless because of too many limitations and restrictions that leave hospital and doctor bills unpaid.

The story quoted Robert Reich of the Federal Trade Commission as saying:

> The coverage is not good at all. And the companies are making a large amount of money. Cancer insurance is really an embarrassment to the industry.

In June of 1979, the National Credit Union Administration, the Federal agency established by Congress to oversee the operations of credit unions, began an investigation of cancer insurance given evidence that many credit unions were sharing their mailing lists with cancer insurers. It appears that the credit union would receive a percentage of premiums paid on each policy as their share for this cooperation. Often the fee is billed not as a commission but as administrative expense—a convenience perhaps to avoid violation of State laws which say that commissions cannot be shared with unlicensed individuals.

On June 24, 1979, Lawrence Connell, Chairman of the Administration, made a tough speech before the Credit Union Executive Society. He said in part:

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> Among new areas of cancer at NCUA is the sale of cancer insurance and other group buying plans * * *. It would be the most egregious affront to credit union principles to endorse or to recommend a service to members that preyed upon their deepest fears. At NCUA, we will be studying sales of cancer insurance and other products which are endorsed by leagues. We have heard rumors that attractive commissions have been a common sales technique. Federal credit unions are prohibited from receiving reimbursement in excess of their administrative costs. We will enforce that regulation so there will be no direct threat to the integrity of their operations. However, we do have a concern about indirect compromise.
>
> We will conduct a study of insurance services sold to members through their credit unions.

On June 13, 1979, Chairman Pepper released a report by the U.S. General Accounting Office which was asked to analyze the economic value of various dread disease and other Medicare supplementary health insurance policies. Part of the reason for Chairman Pepper's request to GAO was due to confusion about accurate loss ratio figures for various companies selling cancer insurance. Following are highlights from GAO's report:

> Loss ratio is the proportion of gross premiums which, on the average, is returned to policyholders in the form of benefits. As such it is an indicator of economic value of a policy form or forms offered for sale by an insurance company. Loss ratios are usually expressed in percentages. For example, if the loss ratio for a year (or other specified period) were 55 percent, this would mean that total benefits paid to policyholders—for illnesses originating during the period—would amount to 55 percent of the premiums which they had paid.

Moreover, although the loss ratio is used as a measure of economic value, it does not reflect other factors which should be considered in determining economic value such as:

> What other insurance is available covering the same illness or other contingency?
>
> Is the individual's financial situation such that he/she can reasonably afford to buy the insurance?
>
> If an individual has other insurance covering the same contingency, will benefits payable on the new or an existing policy be reduced accordingly under a provision for coordination of benefit?
>
> GAO noted that the National Association of Insurance Commissioners suggested an accepted loss ratio guideline of 40 to 65 percent for health insurance policies issued to individuals and a minimum of 60 percent for policies sold in supplementation of Medicare.
>
> GAO determined that the following were accurate "aggregate actual loss ratios" for cancer insurance policies issued by the companies named below:

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| | Number of policy forms identified | Premiums earned (millions) | Losses incurred (millions) | Loss ratio (percent) |
|---|---|---|---|---|
| Union Fidelity Life Insurance Co., Trevose, Pa.—1976 | 9 | [1] 4.8 | 0.9 | [1] 19 |
| Libert National Life Insurance Co., Birmingham, Ala.—1977 | 14 | 21.3 | 5.5 | 26 |
| American Family Life Assurance Co., Columbus, Ga.—1977 | [2] 8 | 152.6 | 64.9 | 43 |
| Colonial Life and Accident Insurance Co., Columbia, S.C.—1977 | 5 | 5.2 | 2.5 | 49 |
| Lone Star Life Insurance, Co., Dallas, Tex.—1977 | 3 | 9.9 | 5.5 | 55 |

[1] 1 policy form accounted for $4,500,000 or 94 percent of the $4,800,000 in total premiums earned on the 9 policy forms. This policy form reported $3,200,000 in premiums earned for the 1st year with a loss ratio of 13 percent, and $1,300,000 in premiums earned for renewals during 1976 with a loss ratio of 37 percent.

[2] This number does not include policies no longer issued which the company grouped together for reporting purposes. Of the total premiums earned, $1,600,000 is applicable to these policies.

In June 1979, the Senate Banking Committee opened an investigation of cancer insurance in the face of significant evidence that not only credit unions but also major oil companies and banks through their credit cards have been offering cancer insurance.

On August 28, 1979, the Wall Street Journal quoted Robert Reich, Director of the Office of Policy Planning and Evaluation of the Federal Trade Commission, who said:

> There is evidence that many companies selling cancer insurance are preying on the customer's fears of cancer through the use of scare tactics.

The Journal noted criticism from established health insurers:

Buying a cancer policy alone, instead of a comprehensive insurance plan, is like "insuring a ship against fire but not against sinking," says Thomas, A. Harnett, senior vice president and counsel of Travelers Insurance Co. of Hartford, CT.

On September 18, 1979, the Massachusetts Department of Insurance banned the sale of cancer insurance and referred several cancer insurers to the attorney general for possible legal action.

A report—chronicling the most in-depth investigation of cancer insurance ever undertaken by any State—was issued. Among its recommendations was a complete ban on cancer insurance.

In banning cancer insurance, the department decided this coverage is often uneconomical, duplicative of existing health insurance, and sold on misleading terms.

The practical effect of the regulation is that any company which wishes to sell dread disease insurance must cover a broad range of such diseases—such as heart disease, various kinds of paralysis, chronic lung diseases and severe burns or fractures—and not simply cancer.

Such broad-based dread disease and accident insurance cannot be cancelled before an individual reaches age 65 and may be marketed only to individuals less than that age to prevent salesmen from preying upon the fears of the elderly who are considered adequately protected by a combination of Medicare and Medicare supplemental insurance.

In its December 1979 issue, Changing Times carried a story entitled, "Why Cancer Insurance is a Bad Buy." The story begins:

> The sales letters pull no punches. "Cancer is so horrible and dreaded a disease that the normal reaction is to say, 'It can't happen to me' " Yet, the "odds are very high that someone in your family will be stricken * * * so you must

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protect yourself and your family from the crushing costs * * *. Most people's financial resources are no match for the overwhelming costs of today's treatment."

In part because of such scare tactics, the selling of cancer insurance, which pays off for that disease only, has become one of the fastest-growing businesses in America—even though few major insurers offer it and an impressive array of critics advise against buying it. They charge that insurers are exploiting fear and ignorance to market policies of dubious value.

In March 1980, the House Select Committee on Aging held a hearing and issued a report entitled, "Cancer Insurance: Exploiting Fear for Profit." The major findings and conclusions of this hearing and report follow:

(1) Some companies sell disproportionate number of cancer insurance policies to the elderly.

(2) Some companies improperly imply an endorsement for their product from the American Cancer Society.

(3) Most insurance companies which sell cancer insurance use scare tactics to induce people to buy policies.

(4) Some companies exaggerate statistics to promote cancer insurance.

(5) Companies selling cancer insurance belabor cancer costs.

(6) Companies selling cancer insurance belittle basic health insurance coverage.

(7) Many companies selling cancer insurance mislead the consumer by misrepresenting or exaggerating the benefits of their policy.

(8) Some cancer companies falsely imply an association with the U.S. Government.

(9) Some cancer insurers use phony testimonials.

(10) Some companies sell cancer policies falsely claiming that they are cheaper group plans when they are really individual policies.

(11) Some cancer companies make phony promises that a patient will be paid twice for the same illness.

(12) Companies sometimes sell polices which have not been approved by the State.

(13) Some companies reduce benefits so that the policy the consumer receives provides less coverage than the one they bought.

(14) Some companies say their policies are guaranteed for life and that rates won't increase. However, rate increases are instituted nonetheless.

(15) Companies selling cancer insurance offer a product which has very limited economic value.

(16) Many people will never recover benefits from their cancer insurance policies because of coordination of benefits contained in their major medical plans such as Blue Cross-Blue Shield policies.

(17) Money spent on the purchase of a cancer insurance policy could be better spent on improving one's comprehensive insurance coverage.

(18) Abuses by agents selling cancer or other dread disease insurance policies are widespread.

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(19) Companies selling cancer insurance exercise little control over agents; agents' licensing and training are inadequate.

(20) Cancer policies frequently include uncommon restrictions and limitations.

(21) Cancer policies cover only cancer; with the exception of American Family, most companies imply coverage for other health problems.

(22) Although most cancer costs are incurred outside the hospital, cancer policies unfortunately are geared to pay for cancer costs only when the individual is in the hospital.

(23) Although cancer, by its very nature, brings on related medical problems, many cancer insurance policies do not pay for the cost of these complications.

(24) Some cancer policies will pay only for a certain time limit after cancer is diagnosed—a fact which is not always made known to the policyholder.

(25) In order to limit their liability, most cancer insurers won't pay until cancer is diagnosed by a pathologist, which can be a costly or life-threatening procedure.

(26) In cancer policies, what the big printed gives you, the little print takes away.

(27) Cancer insurance policies often employ obtuse legal jargon or other language confuses the consumer.

(28) Many cancer insurers promise mountains of benefit but deliver molehills of protection.

(29) Even the proffered peace of mind that cancer insurers say that they offer is illusory.

(30) Many companies selling cancer insurance have high rates of denial or errors in their payment claims.

(31) There are serious shortcomings in the procedures for resolving complaints among major cancer insurers.

(32) Some State insurance commissioners are lax in their regulation of cancer insurance sold by agents.

(33) Insurance sold by mail, particularly mail order cancer insurance, presents special problem and is essentially beyond the reach of State regulators.

RECOMMENDATIONS

1. The Congress should require that policies sold to the elderly in supplementation of Medicare provide broad coverage and are not limited to providing protection against the cost of incurring a single dread disease.

2. The States should carefully review and upgrade their regulation of cancer insurance with an eye toward providing requisite protections for all Americans.

3. The Congress should act immediately to help the States regulate and close the no-man's land which presently permits mail order firms to sell cancer and other health insurance policies in States where such policies are not filed with and approved by the commissioner of insurance of that State.

Also in 1980, the Senate Judiciary Committee on Anti-Trust and Monopolies, chaired by Senator Howard Metzenbaum, held two

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hearings on cancer insurance and took testimony from both private citizens and the cancer insurance industry.

On June 9, 1980, the voluntary certification of Medicare supplemental health insurance policies became public law (P.L. 96-265), based on legislation offered by Senator Baucus and then Senator Culver and Congressman Pepper. Among other things, the new law required that a program of voluntary certification for Medigap policies be established; that overselling and the Government look as insurance practices be outlawed; that mail order firms be required to first file their policies with the commissioner of insurance in the State in which the policy is sold; and that a study of State regulation of such insurance be undertaken by the Department of Health and Human Services.

On January 1, 1982, as required by Public Law 96-265, the Secretary of the Department of Health and Human Services (HHS) was to transmit to the Congress the report of his comprehensive evaluation of State efforts to regulate Medigap insurance. The report was not delivered.

On July 1, 1980, as mandated by Public Law 96-265, the Secretary of HHS was to transmit to the Congress the first in a series of reports on the implementation of the voluntary certification system and criminal penalties established by the law. The report was not transmitted.

On July 1, 1982, the voluntary certification program established under Public Law 96-265 became effective.

In September of 1983, the first of four parts of the comprehensive study of the effectiveness of State approaches to the regulation of Medigap was transmitted to the Congress by HHS Secretary Margaret M. Heckler. The other three reports were said to have been delayed by administrative backlogs. The first component of the study reports the results of a survey of senior citizens and a review of State regulatory environments in six States. Issues covered in the consumer section include: policy ownership; characteristics of policies owned; quality of policies owned; sales abuse; and consumer knowledge. Issues covered in the section on State environments include: quality of policies owned; duplicative coverage; sales abuse; and consumer knowledge.

In February 1984, Congressman Claude Pepper, chairman of the House Select Committee on Aging's Subcommittee on Health and Long-Term Care prepared and sent to all State Commissioners of Insurance a detailed two-page questionnaire designed to ascertain each State's experience in the regulation of Medicare supplemental insurance. The results of that survey are discussed in section IV of this report.

On May 3, 1984, the Chairman of the Federal Trade Commission, Michael Pertschuk, gave testimony before the Subcommittee on Monopoly and Commercial Law of the House Committee on the Judiciary. Chairman Pertschuk issued sharp criticism of the insurance industry. He stated, "Insurance consumers continue to suffer tremendous economic injury on a grand scale from inadequate disclosures, deceptive sales practices, and poor State regulation."

In June 1984, Consumer Reports magazine issued a lengthy report on Medigap insurance. It provided an analysis of a sample of

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major Medigap policies and gave tips to consumers interested in purchasing supplemental Medicare insurance.

On June 13, 1984, HHS Secretary Margaret M. Heckler transmitted the Fiscal Year 1981 Medicare Annual Report. This report contained several pages of information relative to Medigap insurance and HHS's activities in implementing the voluntary certification system and criminal penalty requirements of Public Law 96-265. HHS maintained that these pages represented compliance with the report they were required to submit by July 1, 1982, under the Medigap reform legislation.

In the spring of 1986, the Subcommittee on Health and Long-Term Care of the House Select Committee on Aging, chaired by Congressman Claude Pepper, conducted the initial three of a series of hearings on catastrophic health care coverage. The subcommittee heard from Americans young and old across the nation about their personal experiences with the devastating financial and emotional impact of catastrophic illness. Many of the country's leading health policy experts appeared at these sessions, among them former Director of the National Institute of Aging, Dr. Robert Butler; former Secretary of the Department of Health, Education and Welfare Joseph A. Califano; director of the Harvard University Medicare Project, Dr. David Blumenthal; and the head of the National Leadership Council of Aging Organizations, Mr. Jacob Clayman. These and other skilled observers told the subcommittee that senior citizens are left most vulnerable to the devastating effects of chronic illness such as Alzheimer's disease and Parkinson's disease, and long, drawn out terminal illnesses such as cancer. They stated that Medicare and private insurance leave the victims of these catastrophic illnesses unprotected. They urged the subcommittee to make major reforms to the Medicare Program to include long-term care and preventive service coverage.

At the kickoff hearing of the series on February 19, 1986, "Catastrophic Health Care Coverage: Mending a Broken Promise," the subcommittee heard from a Massachusetts man who had been convicted of mail fraud while selling Medicare supplemental insurance to senior citizens. This witness related how he and fellow insurance agents, through an assortment of abusive and deceptive practices, cheated senior citizens hoping to protect themselves against catastrophic illness and the rising cost of health care out of thousands of dollars. He stated that these abusive practices persist today.

On February 24, 1986, Chairman Pepper introduced H.R. 4213, a bill to increase penalties for violations of the mail fraud statute. Under the Pepper legislation current penalties, which have remained unchanged since 1907, would be increased from $1,000 to $10,000 in fines and from 5 to 10 years in maximum jail sentences. In addition, H.R. 4213 grants the Federal Government authority to recoup cash and other assets derived from mail fraud schemes. Many experts feel that this legislation would be a significant step in the fight to combat abuses in the sale of Medigap insurance.

On February 28, 1986, Chairman Pepper introduced H.R. 4287, "Medicare Part C: The Catastrophic Health Insurance Act of 1986." This landmark reform proposal would address the major inadequacies of the Medicare program by offering seniors a new Part C of Medicare which would eliminate all copayments and deductibles

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under Medicare Parts A and B, provide coverage of vital preventive services such an eye, ear and dental care and twice-yearly physicals. H.R. 4287 would also provide coverage for long-term care for chronically ill older Americans. This coverage would be provided not through the expenditure of new Federal dollars but by wiser management of current Medicare funds and elderly health care expenditures. The new part C would unite the best of the innovative genius of private industry with a strong Federal quality assurance system.

In March 1986, Congressman Claude Pepper, chairman of the House Select Committee on Aging's Subcommittee on Health and Long-Term Care, prepared and sent another questionnaire to all State commissioners of insurance, to update his 1984 survey. The results of that survey are discussed in section IV of this report.

### B. STATE COMMISSIONERS CONFIRM ABUSES IN THE SALE OF MEDICARE SUPPLEMENTAL INSURANCE TO THE ELDERLY (1978—PRESENT)

As is apparent from a review of the chronology of public and private activities relating to abuses in the sale of insurance to the elderly, lively debate and scandals have not been isolated events in the last 20 years. The activities in both the public and private sectors are evidence that abuses are fairly widespread and worthy of a national response for reform. The committee's and subcommittee's investigations involving interviews with agents—details later in this section of the report—add additional evidence to this fact.

During the course of its 8-year-long investigation into abuses in the sale of insurance to the elderly, the subcommittee has managed—with the assistance of insurance agents and State insurance commissioners—to develop a new vocabulary of terms used to describe certain abusive sales tactics. The existence of such terms alone seemed further evidence of the fact that abuses are fairly common. In order to learn if this hypothesis was accurate, the committee and its subcommittee, in 1978, 1984, and again in 1986, included a list of 22 common abuses with its questionnaires to all State insurance commissioners. The State commissioners confirmed that a large number of these abuses were found in every State over the course of the past 8 years.

A list of these common abuses will be found below, followed by a tabulation of the number of State commissioners who indicated that they had evidence of that abuse in their State in 1978, 1984, and 1986.

At the time of publication of this report, 30 States had responded to the subcommittee's 1986 questionnaire. Therefore, the 1986 State response will be reported as a percentage of the States reporting.

Examples of specific instances of abuse are also detailed. Also the examples presented are not exhaustive of the examples reviewed by the Subcommittee, but are illustrative of the abusive sales practice:

*Wolf in sheep's clothing.*—The agents fails on initial contacts with clients to disclose that he represents a for-profit insurance company. He may say he is from Medicare and wants to help seniors with any problem they may have.

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Thirty-four States indicated that they had evidence of this kind of abuse in 1978; 33 reported evidence of such abuse in 1984; and in 1986, 38 percent of the States told the subcommittee they had experience with such practices.

An example follows:

> An Illinois insurance salesman began his sales presentations to several elderly consumers by claiming he was working with a senior citizens association. He told the seniors about ways that they could get discounts on their utility bills. He then pulled out his sales brochure, which he called a franchise health plan. The word "insurance" did not appear on the brochure. He said his corporation was not-for-profit and that his company paid out 142 percent in claims. The senior's trust in the senior citizen association clinched the deal. They, like others, bought his story and his policy.

*Pie in the sky (or "fine print").*—The agent misrepresents policy content with words like "no waiting periods," "This policy will pay for everything," et cetera.

Thirty-nine States said they had evidence of agents misrepresenting policy provisions in conjunction with the sale of Medicare supplemental and other health insurance policies in 1978. In 1984, the picture had not improved—41 States reported such abusive activity. By 1986, 97 percent of the States reported evidence of such practices.

Several examples follow:

> In Delaware, the wife of a retired colonel in the U.S. Army made 8 different claims on her Medicare supplement policy purchased through a retired Army officers group. These claims included a diagnosis for hypertension, x rays and treatment for a broken foot, treatment for neck spasms, and a claim for bronchitis and possible pneumonia. After paying $1,600 in insurance premiums, she received only $15.25 reimbursement from the insurance company—even after the agent assured her that all of the above conditions would be fully covered under the policy.
>
> An elderly Louisiana woman developed cancer. Her hospital bills came to $747.50. The insurance company paid $112.50, only $24.87 greater than her $87.63 premium. The agent claimed her policy would cover all expenses associated with a bout of cancer.
>
> One agent promised a Midwest family of an Alzheimer's victim that he had the only full-coverage custodial care plan available on the market. However, a reading of the policy indicated that in order to receive this care one had to be in a skilled nursing home It didn't cover custodial care at all.

*The Government look.*—Agents and/or companies often use advertising materials that tend to associate them with the Federal Medicare or Social Security programs. Using the above, the agent implies that he is from a Government agency without saying so outright. This activity was outlawed in the 1980 legislation.

Thirty-eight of the States responded affirmatively when asked about having evidence of the existence of this abuse in their States in 1978. By 1984, 38 States again responded that they had evidence

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of such abuses; and in 1986, 72 percent of the States reported experience with such abuse.

Examples follow:

A California insurance agent fraudulently induced an elderly woman to apply for life insurance with a well-known company by claiming that the agent worked with the "Old Age Pension," thereby leading the woman to believe it was associated with her Social Security benefits. The agent then tried to get the woman to purchase the policy after she refused by promising to discount the premiums if she paid cash. This is an unlawful rebate in violation of section 250 of the California Insurance Code.

In 1983, the subcommittee received numerous inquiries from concerned seniors nationwide regarding solicitations they had gotten from the Federal Government asking them to purchase insurance to cover increases in the cost of health care enacted by Congress. After reviewing samples of the solicitations, the subcommittee concluded that the envelope suggested that the policy was being offered by the Federal Government. The subcommittee took the matter to the State commission of insurance in the State from which these solicitations originated, for followup action.

*Scare tactics.*—The agent employs scare language in closing the sale like "Buy now because you may not be able to be insured later," et cetera.

Thirty-eight States said they had evidence of agents using scare tactics in their efforts to sell Medicare supplementary policies in 1978. By 1984, 38 States still said they have evidence of such activity. By 1986, 90 percent of the States reported experiences with such abuse tactics. Examples follows:

An Illinois staff investigator witnessed a salesman telling a woman that because of the skyrocketing costs of a prolonged hospital stay she should buy one of his Medicare hospital supplement policies. Once she acquiesced and signed for the policy, he reached into his bag and pulled out a copy of a hospital utilization review letter that informed a certain patient that she should have to leave the hospital after only 3 days. The agent said, "You know that the Government forces people out of hospitals and into nursing homes." He then told her he had a terrific nursing home policy and attempted to sell it to her using exactly the opposite argument he had used in selling the hospitalization policy.

A professional staff member of the U.S. House Select Committee on Aging obtained employment with an insurance company selling dread disease policies. The presentation she was taught to use to sell such insurance was designed to frighten and upset people regarding the disease and its cost.

Agents of a California insurance company were taught to use high-pressure techniques to close sales, including using dramatic visual aids. One set of drawings showed a man being rushed to the hospital with a heart attack while another showed men begging, borrowing and stealing to try to pay for health expenses because they had not purchased enough health insurance.

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*Overselling.*—The agent sells the clients more coverage than they need or can pay for, or both (also known as "stacking" or "overloading"). If you have two or more policies offering the same benefit, you only get paid once. This practice was made illegal by the 1980 legislation.

Forty-four States reported they had experience with such abuse in 1978. In 1984, 38 States said they had evidence of "overselling." And in 1986, 100 percent of the States responding said "Yes," they had seen examples of overselling.

*Duplicate sales.*—The agent sells the client additional policies which are in effect duplicate existing policies held by the client.

Thirty-six States said they had evidence of this abuse in 1978. Six years later, 35 States reported such abuse; 90 percent of the States did so in 1986.

Examples of "overselling " and "duplicate sales" follow:

> Frightened that Medicare was not enough, an elderly couple had purchased 13 separate health insurance policies before an investigator at the Michigan Insurance Bureau could stop them from buying more. They were paying $4,000 a year in premiums and still had no coverage for vision, dental, or hearing care, prescription drugs, and other services.
>
> A 76-year-old North Carolina resident was sold 13 health and life insurance policies from one insurance company over a two-year period; she was paying 68 percent of her annual income in premiums.
>
> An 83-year-old woman from Minnesota owned 28 insurance policies when she died. Over her last 5 years, she spent $15,000 on premiums. Yet, none of the 28 policies covered nursing home care, though she spent the last 18 months of her life in a Minnesota nursing home.
>
> A Wisconsin woman purchased 19 policies from six agents at an annual cost of $4,000. Unfortunately, most of the policies were worthless because of the duplication and overlap of coverage.
>
> A Florida couple, ages 82 and 78, neglected repairs on their refrigerator, television and stove because they were trying to keep up a $2,880 annual premium on 19 separate insurance policies.

*The add on.*—The agent, after selling one policy, includes in the "forms for signature" by the client a second or third policy, stating when asked, "You'll need this too!"

Twenty-five States answered "yes" about add ons in 1978. In 1984, 26 States reported evidence of such activity. By 1986, 50 percent of the States reported the add on.

An example follows:

> The irate daughter of an 87-year-old Californian wrote the subcommittee about nine health insurance policies she discovered in the possession of her father—all from the same agent and from three different companies. There were three indemnity policies, two cancer policies, two service policies, a nursing home policy (which turned out to be an indemnity policy) and a hospice plan. Her father said, "He told me I would need all of these—he called it a package deal. Then he came back and said I should have another 'package' for complete protection."

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The daughter urged the subcommittee to look into insurance matters, stating, "My father was spending a lot of money because he trusted that agent's advice. He can't afford all that."

*The Medigap bandwagon.*—The agent sells the client additional accident or life insurance as if it were part of a comprehensive Medigap plan.

Twenty-nine States responded affirmatively in 1978. In 1984, an identical number of States replied, "Yes." In 1986, 53 percent of the States reported evidence of such abuse.

An example follows:

In New Jersey, an agent for Company C and 16 other companies refused to even examine a prospective client's policies. He saw the name of the company on the outside and concluded they were worthless. He told the woman she needed six different policies. He told her to buy Company C's Medicare supplement plan and Company X's cash hospital benefit plan. He said the two complemented each other. He pulled out Company C's nursing home policy, and the cancer policy from another company. When he told the an she needed a burial plan, she shrieked openly. To cal · fears, the agent said, "Oh, you don't like blue. Well, got the same thing in green. We call it our Life Plan." With that, he pulled a green brochure from his bag.

*The fence post policies.*—The agent completes applications in the name of relatives or others, unbeknownst to the victims. This is done to bypass underwriting rules when it is known the victims already have the maximum coverage in effect with a company.

Eighteen States said they had recent evidence of this kind of abuse being perpetrated by agents in 1978. In 1984, 13 States reported such abusive tactics. In 1986, 23 percent of the States said they had experience with such abuse.

Here is one example:

One State reported to the subcommittee instances where agents were selling more insurance than a company would allow to be sold to an individual. They would change the recipient's name from John Robert Doe to J.R. Doe or J. Robert Doe, in order to bypass having the limit checked by computers.

*Forgery.*—The agent either signs someone's name to the insurance forms or encourages the elderly client to illegally sign the name of the insured's loved one.

Thirty States told the committee in 1978 that they had experience with agents forging signatures or engaging in other illegal activities such as writing fictitious policies. In 1984, 33 States reported experience with such abusive tactics. In 1986, 63 percent of the States responded affirmatively.

Examples follow:

The attorney general of Minnesota, Hubert H. Humphrey III, found during an investigation into the sale of health and life insurance to the elderly the widespread practice of forging signatures on applications for insurance. Such cases of abuse occurred when agents learned that individuals already had the same coverage. The agent merely traced the client's signature as it appeared on their original policy onto another application.

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An elderly woman in Sibley County, MI, signed an application and wrote a check in the amount of $448 as premium for 1 year, only to find out that her policy was with another company at a cost of $443 for 6 months.

Another woman in Minnesota mistakenly applied for a health insurance policy which she had previously bought from the same insurance company. Instead of returning her check, the agent and his employer merely traced the signature onto a life policy and pocketed her money.

*New is better (twisting or existing policies are garbage).*—The agent encourages the client to cancel perfectly good existing policies to sell a new policy which results in additional commission fees.

Some 44 States responded that they had evidence of this violation, ranking it as the most widely reported abuse along with overselling, in 1978. By 1984, 41 States reported evidence of this activity, and by 1986, 93 percent of the States said they had experience with "New is better."

Examples follow:

An agent came to a 83-year-old North Carolina woman's home and asked to see what type of health insurance she had. When she told him that she had Medicare and Blue Cross, he replied, "You don't need that garbage. You need my policy."

In June 1986, an agent reviewed a policy held by a subcommittee senior citizen investigator, told her it was "not health insurance," and proceeded to pitch his policy.

*More is better.*—The agent represents that his policy, which has a higher premium than the competition, is better simply because of higher premium. He may make inflated claims about the coverage provided by the purchase of several policies. In most cases, such policies contain coordination of benefits clauses which means that only one policy will pay.

Twenty-six States said that they had evidence of this abusive sales technique in 1978. In 1984, 20 States said they had experience with this abuse tactic. In 1986, 57 percent of the States responded in the affirmative.

An example follows:

In Virginia, an agent reviewed the policy of a subcommittee senior citizen investigator and then compared it to his policy. Even though an analysis of both types of coverage revealed almost total duplication, he told her that his was double her annual cost because it was better. He said, "You get what you pay for."

*Make the check out to me.*—The agent asks that the client make the check out directly to him. The agent then cashes the check and does not report the transaction to the insurance company. No policy issued.

Asked specifically about this variation—the agent absconding with premiums paid—in 1978, 40 States said they had recent evidence of such violations. In 1984, 40 States said they had recent evidence of such violations. In 1984, 39 States reported such violations. By 1986, 87 percent of the States reported evidence of such illegal activity.

Examples follow:

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A Buffalo, NY, insurance agent swindled more than $100,000 in phony insurance annuity policies. He would convince his elderly targets to drop their existing policies in favor of his company's. He would then pocket the premiums but never send the applications to the insurance companies.

A Massachusetts woman had 25 health insurance policies, the annual premium for which totaled $8,000. Many times, the insurance agent advised her to make the check out to the agent. One of these same agents would later come around to collect the cancelled checks in order that he could not be caught.

*Postdating application.*—Agent postdates application to avoid maximum coverage guidelines. Net result is that client is often not covered for the initially agreed upon period.

Fourteen States reported evidence of this type of abuse in 1978. In 1978, 19 States said they had evidence of postdating applications. In 1986, 30 percent of the States responded "Yes."

An example follows:

A California agent sold four policies to a couple for the purpose of protecting them from cancer. The agent returned with life insurance policies from different companies—none of them covered cancer. The policies were rejected by the couple but no refund was made until they contacted the California Department of Insurance. There was evidence that the agent altered the date of application on all four policies without authorization from the couple.

*Corporate twisting.*—A conspiratorial arrangement whereby two or three companies transfer aged customers among themselves. This results in the expiration of policies which are in force, in favor of newly acquired policies with waiting periods.

Twelve States responded affirmatively to the above described abuse in 1978. In 1984, 11 States reported experience with such activity. By 1986, 17 percent of the States said they had encountered problems with this abusive sales techniques.

An example follows:

Four insurance salesmen in Massachusetts were convicted after defrauding elderly citizens of over $100,000. These four salesmen worked together by exchanging names of vulnerable victims who were easy sales, and alternating visits to those people to maintain a fresh face sales approach. The victims were sold thousands of dollars' worth of unnecessary insurance.

*Clean sheeting (or failure to report material condition).*—The agent fails to report preexisting health conditions of clients to company, ultimately leading to a preexisting condition disqualification of coverage when claims are filed.

Forty-one States answered affirmatively when asked whether they had evidence of agents engaging in this abuse in 1978. In 1984, 40 States still said they had experience with clean sheeting. And, by 1986, 97 percent of the States reported in the affirmative.

Examples follow:

A diabetic man who had taken out a cancer insurance policy contracted cancer and was forced to stay in the hospital 10 days. The company refused to pay for more than 4 days, argu-

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ing that he would not have been in the hospital more than 4 days if he were not a diabetic.

Five salesmen under the guise of several insurance agencies defrauded 100 elderly residents of Massachusetts and Maine out of $200,000 by falsifying health histories, overcharging insurance premiums, and misrepresenting insurance products.

An agent sold a policy by telling a senior citizen with a preexisting heart condition that the insurance company would cover up to $1,200 for heart surgery, although in fact the preexisting condition would preclude the senior citizen from coverage for that ailment entirely.

*The switch.*—The agent sells the client one policy but then switches and provides another for signature at the time of closing.

Twenty-five States responded affirmatively when asked if they had evidence of this abuse in 1978. In 1984, 17 States told the subcommittee they had evidence of such abuse. And, in 1986, 43 percent of the States reported that they were aware of such activity.

Examples follow:

An Arizona agent deceived an elderly couple by wrongly telling them that their current insurance company had changed its name in an attempt to swindle them out of the money they thought they were spending to renew a legitimate policy.

In Iowa, an agent switched companies. One of his clients, who wished to stay with his original company, gave the agent in question a blank check, which he filled out to his new company, never telling the woman.

*Just dropped by.*—The agent comes by for a visit, perhaps to collect the premium or drop off a new claim form, all the while intending to sell more insurance.

Twenty-nine States responded positively in 1978; 32 in 1984, and 77 percent of the States in 1986.

Examples follow:

An elderly woman living in southeastern Idaho was called on by two insurance agents periodically and unannounced over a period of approximately 6 months. Later it was discovered she had paid close to $9,000 for policies she didn't need but felt obligated to purchase after spending time with these agents.

An elderly woman from northern Idaho had four agents working out of the same insurance agency call on her to visit repeatedly, for a period of 12 months. During this period, they wrote policies through several different insurance companies. By the time the agents were discovered, she had paid out over $11,000 in premiums.

Members of a Texas investigation on Medigap fraud discovered that a number of agents use hit lists in identifying and locating aged victims who are individually known to be susceptible to repeated health insurance sales. Among the many examples they provided was an 84-year-old woman who paid out at least $15,000 for 23 health insurance supplemental policies over a 2-year period.

*Group policy.*—The agent represents the policy as a group policy with the implication that premiums are less, when in fact there is no group and the policy is the same in coverage and premium as a regular policy.

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Twenty-one States said they had evidence of this kind of abuse in 1978. By 1984, 17 States reported evidence of such abuse. And, in 1986, 47 percent of the States replied affirmatively.

An example follows:

> An elderly gentleman from Vermont wrote the subcommittee in 1985 and attached a copy of his health insurance policy. He asked the subcommittee if this policy was one senior citizens buy, because that is what his agent told him and that convinced him to drop the Blue Cross/Blue Shield policy he had held since his retirement. The subcommittee found the policy not only not to be associated with a senior organization but also less comprehensive than the insurance he had dropped and couldn't recover.

*The stall.*—The agent delays in delivering the policy, which is not effective until delivered, thereby exposing the client to the risk of loss of coverage. Another variation is the delay in responding to the requests of a newly insured person to discuss cancellation of policy. Time limits for cancellation are thereby exceeded.

Twenty-seven States said they had evidence of this abuse in 1978; 6 more States, for a total of 33 States, reponded affirmatively in 1984, and in 1986, 70 percent of the States responded "yes."

An example follows:

> An elderly gentleman from Louisiana wrote the subcommittee to urge the Congress to do something about insurance companies. He said he bought a policy and was told he could look at it before he decided to keep it. After giving the check to the agent, he waited 2 months before the policy arrived in the mail. Upset about the delay and deciding he didn't want to deal with a company that was slow in delivering a policy, he sent it back and asked for a refund. A form reply was received explaining his right of cancellation had expired and a rebate would not be possible.

*Low weekly rates.*—The agent quotes premium prices on a weekly basis but closes and sells on an annual basis.

Fifteen States responded affirmatively in 1978. In 1984, that number had increased to 17 States responding "Yes." By 1986, 25 percent of the States reported evidence of such abuse.

Examples follow:

> An agent told a subcommittee senior citizen investigator that his policy would only cost her about $177 quarterly—and then proceeded to tell her it would be better to make an annual payment because a discount would apply. He added, "It sounds expensive, but it's cheap when you need to use it."
>
> In 1978, a committee investigator was told by a company representative selling insurance, that, "If you can't afford $5 a month, then you certainly can't afford cancer, can you?" This same sales pitch resurfaced in D.C. in 1986, when an agent told a subcommittee senior citizen investigator who mentioned to the agent she liked to pay monthly premiums because she didn't want to die and have paid more than she should have for insurance. He replied, "Well, if you are that concerned about limiting your financial investment for health security, I am not sure you need to talk to me. Health is a long-term investment."

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*I work with.*—The licensed salesman allows an unlicensed person to front for him.

Twenty-eight States said they had evidence of this brand of illegal activity in 1978. In 1984, an identical number of States reported such activity. And, 1986, 70 percent of the States said they encountered such abuse.

An example follows:

> An agent in Massachusetts told subcommittee staff it was common practice for him to call a friend to present a policy for him if he were busy or tired. Even though the friend wasn't licensed and had no insurance experience, it didn't matter to the agent. He would advise the friend to simply chat with the elderly person and get him or her to make out a check. It always worked, he said.

### C. SUBCOMMITTEE INVESTIGATIONS CONFIRM ABUSES IN THE SALE OF MEDICARE SUPPLEMENTAL INSURANCE TO THE ELDERLY—1978 AND 1986

In looking for another way to learn to what extent insurance salesman engaged in assorted abuses, it was concluded that observing actual sales presentations was essential. This conclusion was reached by the subcommittee in the course of its 1978 inquiry into abuses in the sale of Medicare supplemental insurance to the elderly, and again toward the end of its ongoing eight-year investigation into insurance frauds in 1986. The following summarizes the findings of the subcommittee's 1978 and 1986 experiences in actual sales presentations.

#### THE 1978 COMMITTEE EXPERIENCE USING SENIOR CITIZENS AS TEMPORARY INVESTIGATORS

In mid-year 1978, Margaret Dickson, age 67, and former receptionist in the office of Congressman Claude Pepper was the first senior citizen to be recruited by the House Select Committee on Aging as a temporary investigator. She reacted enthusiastically. Mrs. Dickson was covered by Medicare. In addition, she had supplementary coverage from Blue Cross/Blue Shield, Physician's Mutual and several policies from AARP through the Colonial Penn Insurance Co.

In other words, Mrs. Dickson was already overinsured. She had overlapping and duplicative coverage and was spending far more than she needed to for insurance.

The question the committee sought to answer was what would insurance salesmen do when confronted with a 67-year-old woman who said she needed advice about health insurance. How many would do the ethical and honest thing and tell her she already had too much insurance and then leave?

With Mrs. Dickson, staff members made calls inviting salesmen to visit her. The staff members were careful not to make representations that Mrs. Dickson wished to purchase new policies, but said simply that she wanted advice to see if she were adequately covered. In all instances, subcommittee staff told prospective agents on the phone, before the interview was scheduled, that she was already insured and described the policies which she currently held.



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On that basis alone, a number of agents declined to pay a visit and informed committee staff that Mrs. Dickson was already adequately covered. Unfortunately, less than 10 percent of all calls placed by the committee staff in arranging such interviews resulted in such a response. Ninety percent arranged to meet with Mrs. Dickson knowing what insurance she had. When insurance salesmen arrived, Mrs. Dickson presented her policies and asked for advice. Two committee staff members were present in the room with Mrs. Dickson. One took notes and the other openly photographed each visit.

A 1980 article in the Congressional Quarterly summarized, in part, Mrs. Dickson's experiences:

> Margaret Dickson got some unsettling advice from health insurance agents when she asked them to look over her collection of supplementary policies for Medicare.
>
> Mrs. Dickson was overinsured, but most of the agents insisted that she buy even more coverage. Some dismissed her policies as garbage without even looking at them, and pressed her to replace them with as many as eight new, overlapping plans. One agent grilled her about my tax bracket, my banks, my general financial situation, and then suggested—oh heavens, I cannot say it—euthanasia as a solution to long-term health problems. He also asked her to give him power of attorney over her affairs.
>
> What these agents didn't know was that Dickson, a retired receptionist for Representative Claude Pepper, (D-Fla.), was working with congressional investigators. Her son, who took photographs of the meetings, and the insurance sales trainee sitting in on them were Pepper staff aides.
>
> In 50 such interviews, conducted during the fall of 1978, only eight agents honestly advised, "Gee, lady, I think you've already got too much insurance."
>
> Dickson's case was not unique. Investigators found widespread misrepresentations of what policies pay for, high-pressure sales tactics, agents posing as federal employees, persuading elderly persons to replace adequate policies with new ones just so the agent could get a higher commission, companies that paid out very little in benefits compared to the large amounts they collect in premiums.

In time, additional senior citizens were recruited in other States and the same procedures were employed. Among those who volunteered were Edith Podanski of New Jersey, Betty Hamburger of Baltimore, MD, Lillian Teitelbaum of Silver Spring, MD, Amanda Byrd of the District of Columbia, Winona Montgomery and Isador Monger of Phoenix, AZ, Sara Pittman of Macon, GA, and Gladys Adams of Upper Marlboro, MD.

In all, some 50 interviews were held with insurance agents, some of whom represented more than one company. The visits took place in nine States and the District of Columbia. The States were Arizona, California, Delaware, Georgia, Illinois, Maryland, New Jersey, Pennsylvania, and Virginia. Of the agents who appeared, eight were scrupulously honest and did not attempt to force Dick-

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**STATEMENT OF CECIL W. HUFF, COCHAIR, NATIONAL FARMERS FAIR CREDIT COMMITTEE, NATIONAL SAVE THE FAMILY FARM COALITION**

Mr. HUFF. Thank you, Mr. Chairman, and members of the subcommittee. I am a dairy farmer from Ava, MO; and active in several other organizations besides being cochair of the farmers fair credit committee, which is a committee under the National Save the Family Farm Coalition.

Our committee is a coalition of over 70 grassroots farm and rural organizations from 18 States, who have come together to find an equitable solution to the debt crisis facing family farmers.

The committee has identified three principles that we believe must be part of a plan that adequately addresses the farm debt crisis. Those are:

One, that any bailout be targeted to family farms and that the central focus be to save as many farmers from losing their farms as possible.

Two, that it works to keep both lenders and farmers solvent, but the help to lenders would come first through the farmer being helped.

Three, that it be linked in some way to the ultimate goal of raising farm commodity prices to a fair and livable level.

The National Farmers Fair Credit Committee has spent the last several months writing our own plan that adheres to the principles that I have just laid out. Our plan, now in bill form, is called the fair credit plan, which I would like to talk about today.

Before I speak specifically about our bill, I need to impress upon the members of the subcommittee the seriousness of the crisis today, and the need for immediate and adequate action.

In my State, and in the 17 other States that we have groups in, the story is the same, our farm crisis hotlines are ringing constantly off the hook with desperate farmers both young and old, asking and calling for help. The stress is mounting as these families struggle to put a crop in, while carrying huge and growing debt loads, and trying to keep their children fed and clothed.

It isn't just a few poor managers being squeezed out in a move toward greater efficiency. We are losing our brightest and best educated farmers, the ones that follow the University of Missouri extension line and advocated to incur the debt to buy the modern technology to increase production. We are also losing our older farmers through foreclosures and involuntary conveyance of property, these farmers are losing a life time of labor and their life savings with the stroke of a pen.

These older farmers where considered as moral pillars in society and oftentimes, men of wisdom. Now they are faced with becoming society's new poor.

I won't dwell on the statistics, but I would like to confer with Paul Sacia's statement of the agricultural statistics that one-half of our commercial-sized family farm do not have any money for debt repayment after they pay farm operating and family living expense. The other bills that have been proposed are grossly inadequate.

I was a little heartened to see Dean Kleckner's proposal that he called a two-tiered debt system, we called it debt tabling 2 years ago in the grassroot movement. That is not a new concept to us. I am a little heartened that Farm Bureau is catching up with some of the problems that are facing the farmers.

This alarming fact that half of these farmers have no money, has a significant impact on the effectiveness of most of the proposals for emergency debt relief that are being discussed. There are several proposals being discussed today that propose restructuring debt with the combination of lender forgiveness, Government assistance to write-down loan principals and interest rates. But all have the common flaw that they will not save a substantial portion of our commercial-sized family farmers.

With each of these proposals there is an underlying assumption that we just cannot just can't save everyone. There are just some farmers that will have to go under, that is their assumption. We do not concur with that, there is too many farmers lost in the land today already without adding more to it.

In light of the financial conditions over half the family farmers in trouble however, these some farmers that they indicated that can't be saved turns out to be a substantial number and actually might let the food producing ability of the American agriculture fall out of the family farms control.

These plans simply do not offer an adequate relief if the goal is to save our family farm type of agriculture, what is left of it.

This is why we are proposing the fair credit plan; it is a comprehensive debt relief plan that really speaks directly to the issue of saving most of our family farmers in trouble.

The fair credit plan would be federally funded; State-administered emergency response to the financial crisis in agriculture. The major features of our bill that it applies to all agriculture lenders, and this includes individuals. And in none of the proposals I have heard here today did any of the proposals address owner-financed property.

And the statistics that I am looking at say that owner-financed property in this country is equal to what the insurance companies are financing, will run into the midteens of the total farm debt or financed by past farmers and individuals. And our bill intends to give those people the same options that the State, that the Farm Credit System has in their bill, or proposed write-down in other bills.

I noticed I am running short of time. I do want to submit this for the record.

The one thing I want to point out to this subcommittee is I think this farm crisis that started 5 years ago, is now a rural crisis affecting so many other businesses, school districts, county courts. The thing to me is that this is worse than any natural disaster that has every hit anywhere in the United States of America. And the reason that it is worse is that it cannot be accepted by the people in the country. We can accept acts of God, but we cannot accept acts of man.

This farm crisis is man-made; and this farm crisis can be turned around when we as individuals, and we as groups decide that we

want to turn it around. And it won't be turned around until we make that decision.

That that is why we as rural people cannot accept this crisis that is happening, because it can be corrected.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Huff appears at the conclusion of the hearing.]

Mr. JONES of Tennessee. Thank you very much, Mr. Huff, we appreciate your being here.

The next witness is Dr. Barry Casper, Crisis in Agriculture Project, Carleton College, Northfield, MN.

**STATEMENT OF BARRY M. CASPER, DIRECTOR, CRISIS IN AGRICULTURE PROJECT, PROGRAM IN SCIENCE, TECHNOLOGY AND PUBLIC POLICY, CARLETON COLLEGE, NORTHFIELD, MN**

Mr. CASPER. Mr. Chairman, members of the subcommittee, I am pleased to have the opportunity to testify before you today on behalf of the fair credit plan, and to contrast it with other emergency agricultural credit proposals you will be considering.

I would like to submit for the record, both my written statement and a short discussion of how the fair credit plan would be implemented, with your permission.

Mr. JONES of Tennessee. Without objection it will be make a part of the record.

Mr. CASPER. [Displays charts.] Most of the proposed emergency credit plans have one element in common, as shown in a chart I would like to show you.

What happens in almost all the plans that we are hearing about now is that if you take the farmers debt, which might be a couple of thousands—$100,000—up at the top line up there—what almost every one is saying is that the first thing that should happen is that the lender should write down that debt somewhat. And then many people are advocating that that loss be written off over several years in order to make it more tolerable to the lenders. We certainly would accept that policy.

But after the write down there frequently remains a gap in the written down debt. That is what I have shown there. There is another line down there which is the debt that the farmer can cash flow.

And after the lender has written down the debt somewhat you have still got this gap, that is where the Federal Government comes in, and that is where the various proposals that you are going to be hearing about, differ significantly. They have very different gap philosophies resulting in very different outcomes for the farmer in trouble.

To aid you in assessing the desirability of the emergency plans you will be hearing about today and in the coming weeks, I want to propose a critical test. You should ask the proponents of each plan to answer clearly and directly the following questions:

How many of the farmers in trouble today will be saved by the emergency credit plan you propose? How many of those farmers who are in trouble today will lose their farms?

The fair credit plan provides a framework for analyzing for a given government expenditure what the answers to those questions will be.

I want to urge you not to be satisfied with vague replies like: Of course, some of the farmers in trouble will not make it.

We have already heard that today from one witness. What you will find if you will probe more deeply is that some of the proposals receiving the most attention so far would amount to a triage policy for the American family farm. The sum of the farmers who won't make it under the terms of these proposals would be a third or more of the commercial family farms.

Of course, it requires careful analyses to answer in detail the question I propose. But some general effects are easy to spot. Statistics compiled by the U.S. Department of Agriculture on the financial condition of farmers makes clear why the alternative proposals are adequate and the fair credit plan is needed. You have this one fact stated, but I want to underline it.

As of January 1, 1985, the latest figures released there was a striking fact about the family-sized commercial farms experiencing financial stress. If what we are doing is not trying to take a look at those farmers who are in trouble, say, those who have a debt to asset ratio with their lenders, so those that a debt to asset ratio greater than 40 percent say.

What the USDA statistics show is that after paying farm operating and family living, approximately one-half of these farm families had no income at all left for debt service. That was 1 year ago, and in the meantime commodity prices have declined even further.

So, for many of the family farmers in trouble today, the cash-flow situation is not really like the one that is shown in the first chart, which is kind of the way people seem to make—is implicit in some of the descriptions that you will hear from proponents of other plans.

Rather, it is like that shown here in the second chart. For half the family-sized commercial farmers in trouble today, the debt the farmer can cash-flow is around zero, so the gap is enormous. What this demonstrates directly is that proposals such as that of Minnesota Senator Boschwitz, or Oklahoma Senator Nickles, or Iowa State economist Neil Harl that purport to those tens of thousands of family farmers in trouble by writing down their debts and/or their interest rates is not going to be enough.

The great majority of these farmers will still be unable to meet their loan obligations. So these debt-restructuring proposals, no matter how good they sound, or no matter how well-intentioned their proponents, are inadequate to cope with the seriousness of the emergency.

Before you act—don't take my word for it—before you act ask the Congressional Budget Office to analyze each of the proposals and then report back its estimate of how many farmers will be saved and how many will lose their land among those farmers that are in trouble for every plan that you are hearing. For most of the family farmers in trouble to survive this crisis a temporary Government loan of additional money to make up the difference between what the farmers can afford to pay at today's commodity

prices and the written down debt payments that will be required. And that is the essence of the fair credit plan.

Let me just add by commenting on one particular proposal that I think deserves particular mention, and that is the Bedell-Daschle bill. As I understand it that proposal and the fair credit plan have the same gap philosophy. The gap that remains between the debt the farm can cash-flow and the written down debt must ultimately be closed by an increased in farm income if our family farms are to survive.

If farm commodity prices go up significantly this year, as in the price part of the Bedell-Daschle bill, then the credit part of that bill in which lenders write down farmer's debts to the level that they can cash-flow makes, sense. With higher commodity prices the write down to farmers' debts cash-flow levels would be tolerable to lenders.

But if commodity prices do not go up this year, a lender write down to the level where many farmers can cash-flow is exemplified by that huge gap on that last graph, now would impose an unacceptably heavy burden on the lenders.

The fair credit plan would limit the lender write downs to acceptable amounts, whether commodity prices go up this year or not. At the same time, it would keep farmers on the land through a loan to fill the gap temporarily, until commodity prices go up.

In summary, then, the fair credit plan would help almost all the family farmers and the agricultural lenders in trouble today. In contrast most of the alternative emergency credit bills are either blatently unfair or woefully inadequate. Some are targeted to rescue one of the two groups in trouble, the lenders, but sacrifice the other group in trouble, the family farmers.

Even those aimed at helping farmers would result in a substantial fraction of the family farmers in trouble today losing their farms. While the Bedell-Daschle bill shares the fair credit plan's gap philosophy, unlike the fair credit plan, it cannot stand alone as emergency credit legislation if its price provisions fail to pass this year.

Thank you.

[The prepared statement of Mr. Casper appears at the conclusion of the hearing.]

Mr. JONES of Tennessee. Thank you very much, Dr. Casper.

Our next witness is Dr. Robert Jolly, professor of economics, Iowa State University, Ames, IA.

## STATEMENT OF ROBERT W. JOLLY, PROFESSOR OF ECONOMICS, IOWA STATE UNIVERSITY

Mr. JOLLY. I would like to make just a few comments so that we can continue this hearing on schedule. First of all, we have been faced with financial difficulties in Iowa and in the United States for the past 5 years, since 1980. Only in the last couple of years has this problem been brought to public attention. It is even in a shorter time frame that we have had reliable national level information on the incidence of the problem and its intensity.

Certainly, as other witnesses have described, we are confronted with a national issue. It does not impact farmers uniformly. We

have heard comments about the three aspects of the three subpopulations within the farm groups, where one group would be experiencing some financial progress; a middle group that was basically holding its own; and then the third of the farmers that are experiencing significant financial stress and the concomitant emotional stress that goes along with that.

One of the problems that we have in trying to understand the types of policy response that might be appropriate for this problem is that the magnitude of change that is likely to occur is sizable, but the pace with which it occurs is relentless but not particularly dramatic.

We have just completed in Iowa a financing status survey. This is an updated telephone survey of Iowa farm operators. In January we found that about 30 percent of the operators had credit arranged, 30 percent did not, and 40 percent said they didn't borrow any operating money. The demographics of that group that did not borrow operating money, as you might expect, these are the older farmers, running smaller operations and nearing retirement.

In the past month and a half, we have seen some progress in meeting their financing needs. Fifteen percent now remain without credit. If we use their expectations of whether they are going to be extended credit or not, this would suggest only 5 percent would not receive credit for the coming year. Two years ago, 5 percent would have created a real sense of alarm. At the moment, it seems to be a statistic that reassures individuals that the crisis is manageable. Five percent of Iowa's 113,000 farmers is a significant portion. I think we need to understand their needs more completely.

It is unlikely that we are going to find thousands and thousands of farmers in any one period of time out on the section line with their suitcases. What we will experience is a grinding process that extends over a 5- to 6-year period. When we're through with it, we will wonder where our farmers have gone and why rural America is such a distinctly different place than it was at the onset of the crisis.

We have recently completed a study, and I would like to share some statistics with you. If you look at the individual farm firm, there are a series of stages that it goes through as it attempts to deal with financial stress. The initial response is to try to improve productivity or cut costs. If that isn't corrective, then the firm will move into a stage where it attempts to restructure debt, extend repayment terms. If that's not successful, then the firm will move into a restructuring of assets in which assets are liquidated, debts are brought down. If that's unsuccessful, then the firm will fail.

Those stages are not unique to agriculture. All financially stressed businesses will go through that general process. But whereas it makes sense in the micro sense, the firm level, to think about a firm moving through those stages, it very often becomes unworkable when an entire industry is required to move through that process in a relatively short period of time. Our estimates would suggest up to 20 percent of the assets held by commercial farmers may be liquidated over this restructuring period, however long it lasts, 2 to 5 years.

The normal volume for these markets is 2 to 4 percent of the asset base. Up to 25 percent of the farm operators could be liqui-

dated, and debt writeoffs could run in the range of $10 to $15 billion. So, as we are looking at policy responses, we need to bear in mind that this adjustment that we face in agriculture easily could exceed the capacity of our institutions, markets and individuals to make this transition. But it's a difficult problem for the political process to face because it is slow. It is deliberate. And it fundamentally will alter the face of American agriculture in the future.

As a consequence, many of these programs that we see proposed attempt in one way or another to buy time, to facilitate the restructuring process, to ameliorate some of the side effects. The proposals that we have or programs that we have available, however, are often written with such restrictive rules such as the debt adjustment program or the interest rate subsidy program that the Farmers Home Administration uses. It is extremely hard to qualify people that could use this bridging assistance, this assistance as they attempt to restructure. As a consequence, the only people that can qualify, if anyone can, are those that may be able to survive without the program.

So, we have in fact an unusual situation in this regard, where we create assistance programs that in fact provide very little assistance because of very restrictive qualification rules.

I think the programs and policies need to be valuated on their ability to help farmers and the institutions that serve the farm community adjust to very different economic conditions and, along with that, attempt to look at income, support mechanisms, support programs for farmers that would target more of the income support into the hands of individuals that are experiencing stress.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Jolly appears at the conclusion of the hearing.]

Mr. JONES of Tennessee. Thank you very much, Dr. Jolly, for your statement.

The last witness on this panel is Ms. Maureen Steinbruner, executive vice president, Center for National Policy, in Washington.

Ms. Steinbruner, we are pleased to have you. You may proceed.

## STATEMENT OF MAUREEN S. STEINBRUNER, EXECUTIVE VICE PRESIDENT, CENTER FOR NATIONAL POLICY

Ms. STEINBRUNER. On behalf of the Center for National Policy's chairman, Edmund S. Muskie, and the members of our board of directors, I would like to thank the chairman and members of this subcommittee for the opportunity to be here today.

The Center for National Policy is a public policy organization based here in Washington. Our purpose is to develop constructive approaches to national problems and to foster better ways of achieving national goals.

For the past year, as part of a longer term project on food and agriculture policy, the center has been among the many groups examining the farm credit problem and addressing the question of whether there might be a reasonable way for the Federal Government to assist farmer-borrowers through the present debt crisis.

We recognize fully that reducing the Federal deficit is a primary objective at this time. Lowering the deficit should, in principle,

benefit the farm sector as well as other sectors of the American economy.

With this in mind, we have tried to identify that segment of all commercial farms having problems with debt specifically, so that any resources committed to debt relief would be used effectively. As you know, research conducted by a number of analysts, including Emmanuel Melichar, Neil Harl, Bob Jolly, who is here today, their academic colleagues, and others at USDA and in lending institutions, has helped to narrow the focus significantly by sorting out different degrees of indebtedness, or debt-to-asset ratios. More recently, using new data from USDA's spring 1985 farm costs and returns survey, the focus has expanded to include the issue of debt service capacity.

After consulting with a number of these specialists, we decided that it would be useful for our purposes to carry this line of analysis one step further.

Thanks to recent reworking of the data by USDA, this further step was possible, and we are now able to estimate with some degree of confidence that about 128,000 commercial farms are in a category which we believe should be considered the primary target group for any debt assistance program. About 66,000 other farms are close enough to being in this category that they could well be included. That would be a total of about 194,000 farms, and this is the number on which we have concentrated.

Let me explain briefly how we arrived at this number in sorting out the question of overall profitability from the specific problem of debt.

We first divided farm operations into three size categories. Based on gross sales in 1984, we counted as large those farms with over $250,000 in gross sales. We counted as medium those farms with between $40,000 and $250,000 in gross sales, and classified as noncommercial those farms with sales less than $40,000.

Second, for the purposes of this study, we looked at what we call farm operating margins, essentially a ratio of net to gross income, intended to reflect the relative degree of profitability of farm operations.

We constructed two different operating margins and compared them. The first margin was arrived at by accounting for direct cash operating expenses except for debt service. The second was arrived at by accounting for operating expenses including debt service.

For the large and medium farms, we then sorted farms by operating margins, dividing them into the categories of negative margin, or net loss, medium margin and high margin. I should note that our analysis suggests that there are a number of farms that are operating with extremely favorable margins, even under current circumstances, and even after debt service. I think Congressman Evans made a comment about 70 cents on the dollar being returned to some of his farmers, and they are in that category.

But about 15.5 percent of the large farms and 16.4 percent of the medium farms report income and expenses which result in a calculation of negative margins before debt service is even considered. That is a little more than 103,000 farms, by these estimates.

After debt service, the proportions with negative margins roughly double, to 35.2 percent of large farms, and 36.7 percent of medium farms. This is approximately 128,000 farms in apparently serious trouble as a result of debt service.

How do these data relate to the information available on debt-to-asset ratios? If we look at the medium farms, we see that the average debt-to-asset ratio for all farms in our medium category is 0.24 percent. That increases to an average of 0.36 percent for just those farms with negative margins.

That's not right; it's redundant. It's 0.24, or 24 percent.

As these data confirm, most farms have relatively small debts, although the averages are high by historic standards.

Also, we find that a not-insignificant segment of the farm sector is only marginally profitable now, or is not profitable at all, without regard to debt service costs, and in some cases at relatively low debt levels.

We believe that these circumstances complicate the credit problem immensely. Programs to deal with credit will not eliminate underlying problems of profitability. And, any program not carefully targeted will benefit many farm operations that are not in need of such assistance for survival.

Obviously, both the sector's income problems and its financial problems are centered in the current depressed condition of the market. What is the likelihood that this condition will change significantly over the next year or two? As you know, most analysts do not believe that aggregate income to the sector will improve significantly over this period. It is generally felt that there probably will be some relief on the expense side, due to declines in interest rates and energy prices. But overall supply and demand conditions are not expected to generate much improvement in farm income, if any, in the near term. And the degree to which interest relief can be granted to those borrowers most in need of it is not clear, given the lenders' need to build loan loss reserves. You spent a lot of time on that subject this morning.

Therefore, the pressure on borrowers, lenders and real estate values seems very likely to continue, particularly in certain regions of the country.

As we note in our study, there is always an argument to be made in cases like this that the Government should take no particular action, and that adjustment should be allowed to occur unimpeded.

We do believe that there are a number of reasons why some action should be taken to relieve the debt stress on the system; but, even if these reasons are not persuasive in current circumstances, it is possible that the stress will get worse before it gets better. Others who are testifying today can speak to this point directly, and I will not attempt to offer a prediction. But I would like to suggest that, if the situation does deteriorate much further, problems could be harder to contain, and there is some risk that options now available will be foreclosed.

In our study we have looked at the range of measures which different individuals and organizations have proposed over the course of the past year, and have tried to assess the costs and feasibility of such measures, using the target group that we have identified.

I will skip over some of this, because you have heard about it already this morning.

A number of ideas introduced into the debate over this issue since the beginning of this year have begun to address the problem of focusing on the borrowers.

In our study, we concluded, as others have, that an assistance program combining a number of the elements suggested in such proposals might in fact be effective.

We examined the range of debt service relief that might be obtained through interest decreases, through stretchout of amortization periods, and through writedown of principal.

We made an effort in this examination to look at some realistic individual debt service examples in order to relate the degree of relief which might be provided to the amount of relief which would be effective. This is difficult to do and requires that a number of assumptions be made about real farm operations, their cash flow situation, and the range of debt they might be carrying. But we belief that this analysis, in spite of its limitations, does contribute to a realistic picture of the possibilities for assistance.

Having done this, we decided that in fact some amount of Government aid could make a significant contribution to the viability of debt restructuring efforts.

We have a specific proposal for such assistance, which we believe could be designed to limit the Government's costs to a minimum in relation to the alternatives, at least the effective alternatives. It would involve lender costs, and it would require borrowers to put some equity on the line. Not all borrowers would be able to take advantage of such a program, and we assume that not all lenders would be willing and able to participate to the extent needed for maximum coverage. But the proposal has the advantage of being designed so that the tradeoff between participation and cost is minimized.

We are in the process of refining our cost estimates right now and will have them available on Friday. We offer this proposal for discussion, and it may well be that it could be useful in relation to other proposals now under consideration by this subcommittee.

I would be glad to try to answer any questions. We will submit the full proposal.

Thank you. I am sorry I ran over.

[The prepared statement of Ms. Steinbruner appears at the conclusion of the hearing.]

Mr. JONES of Tennessee. Thank you very much, Ms. Steinbruner, for your statement.

That does conclude all the witnesses on panel three. I would advise the subcommittee that we are running behind. If there is anything you can do to help expedite the situation, it will be appreciated by the chairman.

We have two Members of Congress who are present to be heard as soon as possible.

Mr. Coleman, you are recognized.

Mr. COLEMAN. I will certainly join you in those efforts to try to keep this back on track.

I would ask all of you to submit to us, if possible, cost estimates of your program, as Ms. Steinbruner has indicated she will do. It is

very helpful to us. We have to consider the ramifications of the budget as we deal with this in order to insure passage, if we were to get something out of this committee. So, we can't just continue in the dark on numbers. And I would appreciate all of you to do that if you can.

Mr. JONES of Tennessee. Thank you, Mr. Coleman.

Mr. Tallon, do you have questions?

Mr. TALLON. No, Mr. Chairman.

Mr. JONES of Tennessee. Mr. Gunderson?

Mr. GUNDERSON. No questions.

Mr. JONES of Tennessee. Mr. Thomas?

Mr THOMAS. No questions.

Mr. JONES of Tennessee. Mr. Franklin?

Mr. FRANKLIN. I have one, Mr. Chairman.

To give you a factual example of a particular farmer in Mississippi, he owns 250 acres of land. He rents 750 acres of land. He plants half cotton and half soybeans. By his own estimates, his equipment is valued at $150,000 and his home $120,000 and the 250 acres at $300,000—a total asset value of $570,000. He owes the Farmers Home Administration $1.6 million. He has had seven loans for the seven past crop years. He has never in one of those 7 years repaid fuliy the crop loan.

Under the debt restructure plan that you are suggesting, all of you together, would this farmer be qualified to be refinanced and kept viable in business? I would like to start with Dr. Casper and go down the line and have you to answer that question.

Mr. CASPER. Those are a lot of numbers coming pretty fast.

Mr. FRANKLIN. You've got total assets of $570,000 by his own figures, and he owes $1.6 million to the Farmers Home Administration.

Mr. CASPER. Right. I think in the kind of process that we described, what would happen is a mediation kind of proceeding where, with the kind of numbers you described there, in the fair credit plan, I should—what wasn't mentioned is, there's a cap on the annual loan that can go to an individual farmer, in order to keep it to small family-sized farmers and——

Mr. FRANKLIN. My question——

Mr. CASPER. Let me finish the answer please——

Mr. FRANKLIN. If you were the dictator, would you refinance or restructure this——

Mr. CASPER. I want to tell you that, under the fair credit plan provisions, which we have submitted, with a $30,000 cap on the annual loan the farmer can receive, that person would not be able to make it——

Mr. FRANKLIN. So, you would not—you would agree that the committee should not come up with a plan that would allow this fellow to restructure and continue in business under that situation? You'll agree with that?

Mr. CASPER. I would say that, with a $30,000 cap on the loan, and with very little land that he could transfer, it would be difficult to restructure the loan.

Mr. FRANKLIN. Mr. Sacia.

Mr. SACIA. I agree with that. Under these circumstances he just wouldn't be able to survive that mediation process.

Mr. FRANKLIN. Dr. Jolly.

Mr. JOLLY. Now, if you're looking at the proposals that you have in front of you or the Farmers Home Program that you have, there's no way on Earth you're going to qualify that individual.

Mr. FRANKLIN. Mr. Huff.

Mr. HUFF. I would think that in our plan he would at least have the chance to qualify. We would run him through. He wouldn't be eligible for the full $30,000; we would ask that he sell off part of his assets, that the debt be written down. My best guess is that he wouldn't survive the system.

Mr. FRANKLIN. You would try to keep him in business?

Mr. HUFF. I would advise him personally to submit under our plan, yes, and with the understanding he would lose a portion of his assets.

Mr. FRANKLIN. Ms. Steinbruner.

Ms. STEINBRUNER. In my understanding, this person has a debt-to-asset ratio of 200 percent, and his land is valued at $4,000 an acre. Is that the way that works out?

Mr. FRANKLIN. No.

Ms. STEINBRUNER. He's got 250 acres that he owns, is that right, and a million——

Mr. FRANKLIN. I think it's $1,200 an acre.

Ms. STEINBRUNER. And $1 million in debt?

Mr. FRANKLIN. $1.6 million.

Ms. STEINBRUNER. He only owns 250 acres, though, is that correct?

Mr. FRANKLIN. And has the right to farm 750 more.

Ms. STEINBRUNER. OK, but his collateral is just that base, plus some equipment, and we don't know what that's worth.

Mr. FRANKLIN. He estimates the value at $150,000. Total assets, his value, is $570,000.

Ms. STEINBRUNER. Right, which is half of what he has outstanding. It doesn't seem to me that you can write down that much, take it out. It's pretty far gone.

Mr. FRANKLIN. Thank you.

Thank you, Mr. Chairman.

Mr. JONES of Tennessee. Thank you, Mr. Franklin.

Does any other member of the subcommittee have a question?

Mr. Evans.

Mr. EVANS of Iowa. Thank you, Mr. Chairman.

I missed most of the questions. Perhaps if I am duplicating something, you will stop me.

I noticed that Dr. Jolly talked about perhaps 5 percent of Iowa farmers would not receive credit. I think that, based on Dr. Casper's estimates and some others, the percentage that would not receive credit was much higher than that. That leads me to the point that I believe to be true. The geographical distribution of this third, that roughly one-third that is in very serious trouble, is not uniform across the United States. There are some areas such as much of Iowa, where agriculture is inherently more economically efficient by virtue of a far lower risk of crop failure, for example, better soil, better climate, et cetera, et cetera.

My question to Dr. Casper is, How would you, or do you think we should accommodate that problem? In parts of the United States—

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northern Minnesota would perhaps be a good example—there are very high risks associated with farming, and therefore a lot of that agriculture is economically very inefficient. You have got the areas of the Sand Hills where you have expensive irrigation water to pump and compared to parts of Iowa, that agriculture is inherently inefficient. You've got very rough, highly erodable lands. You've got lands on the river bottoms that are subject to floods.

The direction that we are going, for better or for worse, is to shrink agriculture into the more productive geographical areas, it seems to me, whether one agrees with that or not.

Would you try to preserve under your system the economically inefficient geographical areas, or would you allow that kind of shrinkage to persist?

Mr. CASPER. Who wants to come out in favor in inefficiency. Thanks.

Mr. EVANS of Iowa. This, of course, is an extremely difficult political question.

Mr. CASPER I think the kinds of issues that you are raising really about geographical differences are really quite important and really have to be considered in developing debt restructuring legislation.

Another thing that is different and which Iowa doesn't come out so well is that the assets have declined much more seriously in Iowa and in the upper Midwest, for example than in many other portions of the country. In some sense the farmers have taken much more of a loss in that area. So, in a debt restructuring plan in which you want to think about sharing those losses, it may be that the leaders would want to take more of a loss in that area than in some other areas like Texas, where, for instance, the land has appreciated.

I think, as we begin to refine the kind of proposal that we made today, that geographical circumstances do have to be taken into account.

Mr. EVANS of Iowa. Well, I do, too. I don't want to belabor the point today, but it is a very difficult question. I don't know how to approach it.

Mr. THOMAS. Would the gentleman from Iowa yield?

Mr. EVANS of Iowa. Yes.

Mr. THOMAS. This is directly in line with some of my concerns. I would just like to add this briefly if I can.

In our part of the country, in the Southeastern United States, I think it is pretty well documented that we have the bulk of the prime land that is in reserve and not in production at this time. We have got adequate underground water, where many other parts of the country, the water supply is being diminished, depleted. We have long growing seasons. The disturbing thing to me is, where we certainly might can point to other parts of the country at this time being better parts of the country to hopefully survive, that we are going to decide who is to survive and not. But if we allow our agricultural structure in that part of the country, the one part of the country where it can be meaningfully increased in the coming years, if we need it, that land is going to go into some other use, pine tree production, for example, where it is lost most often to industrial ownership and institutional ownership.

This is an issue that concerns me as well. I think that what this committee has to realize is not just for the moment in the short time, is it more profitable to select parts of the country where we can be of more help, but we've got to also account very realistically for what our future need for land is going to be and set our goals accordingly.

Thank you for letting me have that remark.

Mr. EVANS of Iowa. I yield back my time, Mr. Chairman.

Mr. JONES of Tennessee. Thank you very much, Mr. Evans and Mr. Thomas.

Thank you very much, panel. We appreciate your being here.

We will take the liberty, without objection, to contact you for any future information we might want from you. We appreciate your testimony.

We have two members of the U.S. House of Representatives who are present to be heard on this subject today. The Honorable Byron L. Dorgan, a Member of Congress from the State of North Dakota, is here. The Honorable Jim Lightfoot is a Member of Congress from the State of Iowa. If you two gentlemen will be seated at the witness table, we will be glad to hear from you.

Mr. Dorgan, inasmuch as you have been around here for a little longer than Mr. Lightfoot, you will be heard first.

## STATEMENT OF HON. BYRON L. DORGAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NORTH DAKOTA

Mr. DORGAN. Thank you very much, Mr. Chairman.

First let me thank the subcommittee for holding these hearings. They are very timely and important to farmers from all over the Midwest and especially the farmers I represent in North Dakota.

Let me depart just for a moment and offer a complete text of my comments for the record and would hope, without objection, they would be made a part of the record, Mr. Chairman.

Mr. JONES of Tennessee. Without objection, they will be made a part of the record.

Mr. DORGAN. I would like to briefly tell you that I just received a call about a half hour ago from a fellow named Albert Markle. His call buttresses the concern of the farmers that I have heard from over the past several weeks in North Dakota. Albert is sitting in St. Thomas, ND, this afternoon on his farm. He would like to be out in the field. He doesn't have an operating loan. He would like to have the petroleum, seed, and the fertilizer to get out and get started farming.

He has been to the Farmers Home Administration. He submitted a loan application. That loan application has been approved. But there's no money. In North Dakota, as in many States at this point, we have $11.6 million in approved loan applications that are sitting at the State Farmers Home offices in Bismarck. But there's no money. So, we have folks like Albert Markle, who today would like very much to be in the field but don't have the operating loan because, even though their loan has been approved, the State Farmers Home office does not have the money to fund it.

I would like to ask the subcommittee and you, Mr. Chairman, to help as much as you can to persuade the Farmers Home Adminis-

tration to move this money out that exists. And there does exist now about $500 million in loan funds that have been transferred, that are available for operating loans through the Farmers Home Administration. I would encourage you to do what you can with this subcommittee to light a little fire under the right people to move that money out now.

Operating loans or spring planting loans don't do any good in July in North Dakota. Now is the time that we need them.

I have been on the phone to the Farmers Home Administration. I don't accuse them of ill will. I do say that the current approach does produce, in my judgment, a bottleneck of funds that are available.

I am not asking for appropriations above that which has already been promised as a result of congressional action and as a result of a transfer in the Farmers Home Administration. But you can imagine, I am sure, all of you who sit on this committee, what it would be like if you were out there this afternoon, wanting desperately to get into the field, knowing that you filed a loan application a month and a half ago. It was approved. You expected to get the money, but it's not there.

I would like your help, Mr. Chairman. I know you have been personally involved in this kind of an issue. I would encourage you to intercede now and intercede as forcefully as you can to see if we can't get this money moved.

[The prepared statement of Mr. Dorgan appears at the conclusion of the hearing.]

Mr. JONES of Tennessee. May I reply, Mr. Dorgan, to your request?

Mr. DORGAN. Yes.

Mr. JONES of Tennessee. Following the testimony to be heard by you and Mr. Lightfoot, Mr. Vance Clark, Administrator of the Farmers Home Administration will be here. We will again convey to him your story and continue to insist that operating money be made available as soon as possible.

One question I would like to ask you just for the record: Do you know how much money has already been sent to the State of North Dakota for operating loans?

Mr. DORGAN. Well, the need for operating loans in North Dakota has already exceeded $30 million beyond what was allocated at the beginning of the year. I think that's the reason there was the need for a national transfer. That condition exists pretty much around the country. The reason for that, of course, is you have these farmers graduating down rather than up, away from the commercial bankable situation, into a Farmers Home need. This drives up the demand for those operating loans. And that's what has happened in our State.

Mr. JONES of Tennessee. That was the real reason that this subcommittee made a request some several weeks ago to the acting Secretary of Agriculture, Frank Naylor, for a transfer of these funds at that time.

Mr. DORGAN. And I appreciate the action of this subcommittee in doing that. I think that it gave voice to the concern of a whole lot of farmers out there who are dependent on that in order to get out

in the field on their tractors this spring and get some planting done.

Mr. JONES of Tennessee. Well, we know how bad that situation is in all the States that we represent, and we hear from all the rest. So, we are going to stay on top of it and do all that we possibly can.

Mr. Coleman.

Mr. COLEMAN. Mr. Chairman, I am not sure what the ground rules are here, if we are going to have Mr. Dorgan stay around or not. But in the event he is going to leave, which would be appropriate, in any event, if he didn't want to stay, I would say that we certainly have a friend, American agriculture has a friend on the Ways and Means Committee because Byron is on that important committee. When we have tax issues that come up, he is one of the first that we visit with and talk to about these issues. I am glad that he is here today expressing himself on the farm credit issue, as we have been able to express ourselves to him on the tax issues through the years.

Mr. DORGAN. Thank you very much.

Rather than deal with the prepared statement, which is on the longer term debt problem, let me say that we have a very serious problem. Some people on this committee and elsewhere in Congress have addressed some serious and thoughtful proposals to deal with it. I have commented on those. But let me stay around for a few minutes and turn it over to my colleague for his statement. I would be glad to answer some questions.

Mr. JONES of Tennessee. Very good. We will hear both of you. Can you stay, too?

Mr. LIGHTFOOT. Sure.

Mr. JONES of Tennessee. Congressman Lightfoot, you are recognized.

## STATEMENT OF HON. JIM LIGHTFOOT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA

Mr. LIGHTFOOT. Thank you, Mr. Chairman.

Before we begin, I would like to second what Mr. Dorgan just had to say. The Secretary of Agriculture was in my district last week. We had identified the very problem that Byron was speaking of. The Secretary kept saying over and over again, the money's there, the money's there. But it's not getting to the pipeline. We are having problems at the local level, at the State level, and certainly at the national level.

One of the commitments we were able to extract from the Secretary was to send some of those people and those bureaus out to hear the story first hand, and maybe we can unplug it. I would encourage you, as Mr. Dorgan did, to impress that upon Mr. Clark when he shows up here in a few minutes.

One other quick sidebar: the guaranteed loan program also is something, I think, that could be very valuable. But the banks aren't picking up on it because they are having to write down their assets. I think all of our colleagues in this room should exert whatever pressure we can to try to get something through the banking side which will relieve that writeoff situation that these rural

banks face, where they could amortize this out over a series of maybe 6 or 7 years, something of that nature.

Since I came to Congress last year, I have shared your profound concern for the economic conditions in rural America. In this common goal, we seek to improve the financial position of the farm community. I welcome this opportunity to let you know of the proposal I introduced to assist in resolving the farm credit crisis. It is my hope that you will consider this proposal along with others that you are reviewing for action.

On January 29, I introduced H.R. 4073, which is known as the Agricultural Investment Act. This legislation was drafted with the advice of rural ag bankers in my district and offers a realistic, less costly alternative for providing lower cost loans for farmers.

The measure creates agricultural savings certificates similar to the All Savers proposal considered a few years back for the savings and loan industry. H.R. 4073 provides that these savings certificates can be issued by most banks and lending institutions at various rates and terms, with the interest earned on them tax free. The pool of money created by the purchase of these certificates can be loaned, by the U.S. Treasury and Secretary of Agriculture, to ag banks for making lower interest loans to bona fide farmers.

My point in this proposal is to lower interest expenses to farmers who otherwise might not cash-flow, one of the most difficult problems cited by farmers, and do this at less cost to the Government than any kind of a direct credit subsidy outlay.

Granted, there would be some revenue loss by nature of the interest on the bonds being tax exempt. But the cost to the Treasury would still be much less than a credit subsidy outlay.

Although the congressional tax committees are reluctant to consider tax-exempt instruments such as this, the temporary nature of the proposal as well as the public interest being served in this area more than justify the use of such a tool at this time. Moreover, it is likely that Congress will preserve the use of some types of tax-exempt bonds where they are demonstrated to be in the public interest.

I have attached a short summary of H.R. 4073 and a flow chart with our testimony. You can look that over at your convenience.

With that, I would be happy to answer a question or two. Thank you for the opportunity to be here.

[The prepared statement of Mr. Lightfoot appears at the conclusion of the hearing.]

Mr. JONES of Tennessee. Thank you very much for your statement and yours, Byron.

The Chair recognizes Mr. Coleman for any questions.

Mr. COLEMAN. Again I welcome our colleagues. Having already made a few comments about Mr. Dorgan, I would also like to tell Mr. Lightfoot how much we appreciate his leadership on farm issues in this Congress.

As a new Member of Congress, I don't know of anybody else who has had as much impact as that gentleman from Iowa has on the important issues that affect Iowa and his district. We have adjoining districts, so we have adjoining problems. Southern Iowa and northwest Missouri border each other and it doesn't cease to amaze me that we have similar problems. A lot of it is weather. A lot of it

is directed at that particular part of the country. I know that Mr. Lightfoot has worked diligently on behalf of his constituents. This suggestion here, a very credible one, I think we ought to take a long, good look at and, hopefully, get something moving on it.

Jim, thank you for being here today.

Mr. LIGHTFOOT. Thank you. I appreciate the comments.

Mr. JONES of Tennessee. Thank you very much, Tom.

Mr. Gunderson.

Mr. GUNDERSON. Let me just be very brief. I can't help but say this is sort of like the before and after testimony. Mr. Lightfoot, I understand, is probably going to be serving on this committee sometime in the future, and Mr. Dorgan already has and has left us. I don't know if you knew the depth of the agricultural crisis when you decided to get off this committee or not, but I have to tell both of you that you are now not just both friends but friends of agriculture. We badly need the kind of assistance both of you have given us out there in the Halls of Congress. This committee is sometimes accused of being parochial. I don't think we are. But we need help outside the committee, and you have been special friends. Thank you both for your testimony.

Mr. DORGAN. Thank you.

Mr. LIGHTFOOT. Steve, if I could just make one brief comment, I think one of the things that we really need to be diligent about, all of us as a group, this particular piece of farm legislation gives the Secretary of Agriculture more discretionary authority than anything we have ever had in history. The actions he takes are going to have a very direct effect on how people are able to repay whatever credit system that is devised to help them. I think it behooves all of us to really keep the Secretary of Agriculture in tune with what is going on.

Mr. JONES of Tennessee. Thank you very much, Steve.

Mr. Evans.

Mr. EVANS of Iowa. I, too, want to welcome you both with your excellent testimony. I have one technical question to ask.

Byron, you talked about the need for the direct loan funds. It was seconded by Mr. Lightfoot. I would like to know to what extent you think it would be useful to have the advance commodity loan available at this point in time. Would that really help this fellow you were talking about, who is sitting there, for planting money?

Mr. DORGAN. Yes. In the short term, anything that provides some liquidity is helpful. The ability to get fuel, seed, and fertilizer is dependent on some resources made available to those folks.

Mr. EVANS of Iowa. Would an advance on 50 percent of the commodity loan cause him a problem next fall? The point was made earlier. Do you think he is going to manage to——

Mr. DORGAN. Well, I don't know. The problem is, you don't spring plant in the long run; you spring plant at spring. And if you don't have the money to put the crop in, you sure aren't going to have a shot at making a living trying to harvest it in the fall.

When you talk to these folks, as I am sure you find in your district, they are interested in surviving in the short term. There is an abundance of hope out there that somehow, some way, this thing is going to turn around. And if you can simply keep moving until it turns around, you're going to be able to survive.

Mr. EVANS of Iowa. Thank you very much.

Mr. JONES of Tennessee. Thank you, Mr. Evans.

Mr. Franklin.

Mr. FRANKLIN. Thank you very much, Mr. Chairman.

I, too, want to welcome my colleagues and want to take just a minute to lobby my colleague on the Ways and Means Committee about something that is directly bearing on the question that we are discussing here today, debt and farm credit. The Farmers Home Administration has been very helpful in coming to my district, even though we are experiencing the same bottleneck that you described earlier. The money that is available is not being put in the pipeline. However, as a part of the efforts that they are making on those cases, one of which I gave an example earlier in this room when you weren't here, of those farmers who are not going to be able to be financed under any circumstances, the Farmers Home has announced in my district the new homestead provisions allowing the farmer to save his home and 5 acres and have it financed for 35 years on a separate note, and at the same time to apply new regulations that I understand are now being promulgated concerning debt settlement. Authority is given to the State to write down or write off that debt when a farmer voluntarily turns his property in and his land in.

There are tremendous tax consequences to fellows who are in the position of being broke. Many times they are not able to have losses that they can go back and pick up that tax consequence and liability on. It is causing the program to actually be ineffective for many because of the tremendous tax liability that is there. If we could get some assistance—and I have spoken with Mr. Shelby about this—on your committee, he has indicated a willingness to help. If you can understand that that is a problem and be able to work through the taxing committee with that problem, I think that this debt settlement and homestead provisions, the regulations for which are now being promulgated, can work for many, many farmers out there to get rid of this umbrella of debt that is over them and let them at least start to do something else without fear of losing their home and putting their family in the street, et cetera.

Mr. DORGAN. Mr. Franklin, to be very brief, we in passing the Tax Reform bill this past December included a provision in that bill that I helped write, which deals with the alternative minimum tax and the capital gains that a farmer would face upon liquidation. We dealt with it by defining insolvent farmers who are forced to sell everything. What they sell goes exclusively to pay their debts. However, they end up with a tax at the end because they bought land for $200 that was sold for $350. Even if they lost it all, they might have a $35,000 tax bill hanging over their head that won't go away.

We dealt with that on the Tax Reform bill by eliminating that tax consequence for the insolvent farmer. You are raising another issue with respect to certain debt settlements. We have not dealt with it and want to. I am doing some work on it now.

For example, if someone is able to get a loan written down from $300,000 to $270,000, a 10-percent write-down, we don't want there to be an ordinary income tax consequence to the farmer as a result

of the ability of that lender and farmer to agree on conditions that will provide for a cash-flow.

Mr. FRANKLIN. Thank you very much. This is extremely important because I think we have an opportunity to solve many individual problems with the combination of new programs, of the homestead provisions, and also the debt settlement, where a farmer voluntarily turns in his assets. That program is not going to work in several individual cases I know about because of the unbelievable tax consequences that are incurred in trying to get into that program.

Mr. DORGAN. I will keep working on that if you will help me light a fire under Farmers Home to get some more of that money out for spring planting.

Mr. FRANKLIN. I will do it and just as soon as they sit in the seat that you're in.

Mr. DORGAN. I appreciate that.

Mr. FRANKLIN. Thank you, Mr. Chairman.

Mr. JONES of Tennessee. Thank you very much, Mr. Franklin.

Mr. LIGHTFOOT. Mr. Chairman, if the gentleman will yield.

Mr. JONES of Tennessee. Yes.

Mr. LIGHTFOOT. The alternative minimum tax, which went into the tax bill, was finally picked up on the debt reconciliation. The President signed it yesterday morning, so that part of it is taken care of. It goes back to December 31, 1981, which started out over here. So, that part of it is taken care of, fortunately.

Mr. JONES of Tennessee. Thank you, Mr. Lightfoot.

Gentlemen, I want to join my colleagues here on the subcommittee in thanking both of you for your contribution that you have always made to agriculture, and the concern that you have had for the legislation considered in this subcommittee.

Byron, I assure you that Mr. Clark will be hearing your request pretty soon.

Mr. DORGAN. Thank you, Mr. Chairman.

Mr. JONES of Tennessee. He already has, a time or two.

Thank you very much, gentlemen.

Is Mr. Vance Clark in the room yet?

[No response.]

Mr. JONES of Tennessee. We are ready for the 2 p.m. panel. Mr. William Taylor is Director of the Division of Bank Supervision and Regulation, Board of Governors of the Federal Reserve System. Mr. John Downey is Chief National Bank Examiner, Office of the Comptroller of the Currency, Department of the Treasury. Mr. David Meadows is Associate Director, Division of Bank Supervisor, Federal Deposit Insurance Corporation.

Mr. Clark will join this panel when he arrives. He is no doubt continuing to testify before the Appropriations Committee at this time.

Mr. Downey, you are recognized. You may proceed

**STATEMENT OF JOHN F. DOWNEY, CHIEF NATIONAL BANK EXAMINER, OFFICE OF THE COMPTROLLER OF THE CURRENCY, U.S. DEPARTMENT OF THE TREASURY**

Mr. DOWNEY. Thank you, Mr. Chairman and members of the subcommittee for the opportunity to appear before you today to discuss the effects of the downturn in the agricultural sector on national banks. I would like to use my allocated time before you today to present the highlights of my written testimony.

I appreciate your including my written statement in the hearing record.

As you are well aware, the American agricultural economy continues to experience severe difficulties. These problems are being increasingly reflected in the performance of national banks that lend to that sector. Particularly troubled are the 810 national agricultural banks defined by my office as banks having more than 25 percent of their portfolio in agricultural credits.

In 1985, 178 of these banks reported losses, compared with 134 at year end 1984, and only 78 at year end 1983. The median ratio of classified assets or problem credits to gross capital funds at all national agricultural banks reached 52 percent as of September 30, 1985. That is, for every dollar of capital in those banks, there was 52 cents of problem credit.

Problem loans were 30 percent of gross capital in September 1983. In contrast, the ratio for nonagricultural banks rose only slightly over the same period, from 19 percent in September 1983, to 24 percent in September 1985.

The deteriorating condition of many national agricultural banks is also reflected by their increasing presence among the ranks of problem and failed banks. As of year end 1982, only 1 percent of the national agricultural banks were problem banks. By December 1985, 103, or 13 percent of the approximately 810 national agricultural banks, were problem institutions.

Of the 30 national banks that failed in 1985, 10 were agricultural banks. Five of the eight national banks that failed in the first quarter of this year were agricultural banks. We are aware of disruption faced by the communities when a local bank experiences significant deterioration or, in the extreme, fails.

Despite the serious problems facing many agricultural banks, we believe that a majority have sound prospects for the future. Even with larger losses and the likelihood that these losses will continue in the coming months, agricultural banks remain basically sound. As of December 1985, 93 percent of the national agricultural banks reported capital in excess of 7 percent of assets. Fifty-seven percent had capital in excess of 9 percent. While 22 percent reported year end losses, almost 35 percent of the agricultural banks reported a return on assets in excess of 1 percent, the industry benchmark.

For these reasons, we are optimistic that the bulk of the agricultural banking sector possesses the resource, management talent, and willingness to work with their borrowers to achieve mutually satisfactory solutions.

We believe that the most beneficial thing that we can do as a regulatory agency is provide banks with the opportunity and incentives to work with their borrowers to restructure problem loans.

However, many banks have been reluctant to write down loans or to grant other concessions to borrowers because this may reduce their capital levels. Banks fear that reduced capital levels are unacceptable to bank regulators. Furthermore, they are reluctant to reduce capital because it is the basis for determining the amount that a bank can loan to any one borrower.

In response to these concerns of the Comptroller of the Currency in conjunction with the Federal Reserve Board and the Federal Deposit Insurance Corporation decided to institute supervisory policies that would give the banks the tools and the encouragement to restructure problem loans during this difficult but transitionary period. On May 28, of this year, the Comptroller issued a five-point program.

First, we again encourage banks to enter and to work out plans with their agricultural borrowers who are experiencing temporary difficulties.

Second, we repeated our prior encouragement to banks that they familiarize themselves with the opportunities afforded by financial accounting standard No. 15. Under this accounting rule, a bank need not recognize any loss on a restructured loan when the expected payments, principal and interest combined, equal or exceed the loan amount on the bank's books prior to the restructuring.

Third, we are modifying the reporting requirements for restructured loans so that only restructured loans not being paid in accordance with the modified terms are categorized as problem loans. Previously, all restructured loans were reported with problem loans.

Fourth, we instituted a capital forbearance policy to allow well-managed banks whose capital fell below historical levels as a result of problems in the agricultural sector up to seven years to restore their capital. The policy formally acknowledges that capital should be used during periods of unusually heavy loan losses and that capital replenishment takes time.

Fifth, we are amending the rules that limit the size of loans that a bank can make to a single borrower. For banks suffering agricultural losses, we are increasing the current general lending limit of 15 percent of capital to a maximum of 20 percent of capital. Thus, a bank who capital declines as much as 25 percent because of found loan losses will still be able to keep its old general lending limit in order to meet the credit needs of its customers.

We believe that these policies will provide agricultural banks with the incentives and the time to meet the needs of the borrowers they serve. Furthermore, these policies preserve the integrity of banks' financial statements, which is vital to insuring confidence in the banking system. However, in order to improve their ability to withstand future downturns in the farm sector, agricultural banks need to diversify their assets. We have therefore supported Federal and State legislative proposals that would increase small agricultural banks' ability to diversify.

We have encouraged the States to enhance intrastate branching opportunities and to remove restrictions on farm ownership. We have encouraged Congress to expand the powers of national banks and to ease Glass-Steagall prohibitions, of particular relevance with respect to underwriting interests in pools of bank loans.

I will not go into detail on some of these matters, which more appropriately should be and have been the subject of other hearings.

You requested comments on H.R. 3868 and H.R. 4267. My comments relate with respect to H.R. 3868 on the bill as introduced. We understand that significant changes may be made by introduction of substitute provisions. These bills are intended to assist lenders and farm borrowers through the downturn in the agricultural economy. They may, however, create additional inappropriate cost to the Federal Government. We defer to the Department of Agriculture on the need for these specific bills. Nevertheless, we do have some comments on how these bills may impact national banks.

We favor voluntary programs that augment a farm lender's ability to grant concessions in order to improve the ability of troubled borrowers to service their debt. However, as I indicated in more detail in my written statement, any loan restructuring program should contain sufficient flexibility for the lender and the borrower to design mutually satisfactory restructured terms. Statutory limitations on maturity, interest rate, and transferability of restructured loans may lessen the attractiveness of such programs to banks and may actually result in less attractive loan terms to the borrowers as banks attempt to restructure loans within the proposed statutory constraints.

We also recommend that program audits and monitoring of national banks' participation in restructuring programs be conducted by national bank examiners. To do otherwise would result in a duplication of effort by the State agency and the Federal regulator and would unnecessarily increase the regulatory burden on our banks. Historically, Congress has preserved the exclusive jurisdiction of my office over national banks regardless of the subject matter. We are opposed to the provisions in both bills that would permit the loan portion of certain agricultural loans to be amortized on a bank's financial statement over a ten-year period. Loan loss amortization distorts a bank's condition to the public and therefore undermines the integrity of financial reports of both the participating banks and the commercial banking system as a whole.

Furthermore, we believe the statutory creation of an interagency task force to assist agricultural lenders is unnecessary. The financial institution regulatory agencies are already working together on the problems of agricultural lenders and the agencies' recent actions addressing those areas that H.R. 3868 proposes to be addressed by an interagency task force.

Overall, therefore, we would oppose adoption of both bills in their current form. Nevertheless, working together, banks, their supervisors, and Congress, can assist lenders and their farm borrowers through the downturn in the agricultural economy.

Our recent capital forbearance and lending limit actions and your reference to develop appropriate legislation are examples of the kinds of actions that are needed.

I appreciate the opportunity to share our views with you. I would be happy to answer any questions you may have.

[The prepared statement of Mr. Downey appears at the conclusion of the hearing.]

Mr. STENHOLM [acting chairman]. Thank you, Mr. Downey. We will hear from each of the witnesses before we question you.

Mr. William Taylor is Director, Division of Banking Supervision and Regulation, Board of Governors of the Federal Reserve System.

**STATEMENT OF WILLIAM TAYLOR, DIRECTOR, DIVISION OF BANKING SUPERVISION AND REGULATION, BOARD OF GOVERNORS, FEDERAL RESERVE SYSTEM**

Mr. TAYLOR. Thank you, Mr. Chairman.

Mr. STENHOLM Without objection, your statement, as Mr. Downey's, in its entirety will be made a part of the record. We would appreciate very much a summary for this committee today.

Mr. TAYLOR. Thank you, Mr. Chairman. I will summarize.

I am pleased to appear before this subcommittee today to review the problems being experienced by banks in our agricultural communities and to discuss various proposals to ease the strains resulting from these problems.

I think Mr. Downey and others have categorized those problems very accurately. In certain sectors they are fairly severe. The earnings of farm banks have declined steadily and substantially over the decade. Eighteen percent of those banks lost money in 1985. The average return on farm bank equity has dropped from 16 to 6 percent in the short space of 5 years.

In addition, the number of bank failures has increased dramatically in the farm sector, with the number approaching 70 last year.

It is important to note that many of the farm banks are in a strong position. It is modestly encouraging to see recent developments that should work to assist the basic farm economy, including the fall in energy prices and the substantial decline in interest rates.

Having noted all that, I should go on to point out that the prospective supply conditions for farm products suggests that a substantial rebound in farm incomes is not likely to take place in the near future. Accordingly, while farmers that are now financially healthy should be able to avoid serious problems, many other farmers with relatively heavy debt loads face a continuation of serious difficulties.

You have asked that I respond to certain legislation that has been proposed. Like Mr. Downey, I find it very difficult to comment on the budget considerations, as those really are not within my area of expertise. However, I would echo Mr. Downey's concerns regarding the use of loss deferral as a means of dealing with the farm bank question.

We think that the program that we have proposed, as outlined by Mr. Downey, will go a long way toward providing bankers the latitude to deal prospectively with their farm customers and allow those farm customers to adjust their borrowings where such an adjustment will result in the eventual repayment of the loan.

I don't think it is in the interest of the committee's time for me to again go over the specifics of the program. We have already intiated this program and have talked with all of our regional banks.

They are actively pursuing a plan to implement the program in the farm bank sector.

The other point I would like to make is that, given the difficulties we have in the banking business, it would be helpful to have a little more flexibility in the way of dealing with problem banks. Emergency bank legislation which would lower the size of the bank that an out-of-State institution could acquire and the ability to provide assistance to the holding company of the bank as well as the bank would also be helpful.

That would conclude my formal remarks.

[The prepared statement of Mr. Taylor appears at the conclusion of the hearing.]

Mr. STENHOLM. Next we will hear from Mr. A. David Meadows, Associate Director, Division of Bank Supervision, Federal Deposit Insurance Corporation.

**STATEMENT OF A. DAVID MEADOWS, ASSOCIATE DIRECTOR, DIVISION OF BANK SUPERVISION, FEDERAL DEPOSIT INSURANCE CORPORATION**

Mr. MEADOWS. Mr. Chairman and members of the subcommittee, we welcome the opportunity to present the FDIC's views on current farm bank problems and regulatory responses. We have provided a statement for the record, which I would like to summarize for you. In the interest of time, I will try not to duplicate comments that my colleagues made previously.

There are indications that the problems in the farm economy may have bottomed out. Recovery will take time, however. We would expect the number of problem banks and farm bank failures to continue at or near the present level for the next year or two. In the interim, the FDIC and the other bank regulatory agencies have taken steps to deal with the specific problems faced by farm bank lenders. These include a capital forbearance policy, continued recognition of financial accounting standard board statement No. 15, and changing the manner in which renegotiated debt is reported on reports of condition filed with the agencies.

Furthermore, we think that individual States in the farm sector should take action to liberalize branching laws and other laws which might impede recovery in the farm economy.

We also think it is vitally important that the Garn-St Germain Act of 1982 be extended and be eased to allow failing bank acquisitions across Statelines and also a reduction in the size criteria.

This concludes my opening statement. I will be pleased to answer any questions you might have.

[The prepared statement of Mr. Meadows appears at the conclusion of the hearing.]

Mr. STENHOLM. Next we will hear from Mr. Vance L. Clark, Administrator of the Farmers Home Administration, USDA.

**STATEMENT OF VANCE L. CLARK, ADMINISTRATOR, FARMERS HOME ADMINISTRATION, U.S. DEPARTMENT OF AGRICULTURE**

Mr. CLARK. Thank you, Mr. Chairman and members of the subcommittee.

I, too, appreciate this opportunity to discuss ways of assuring farm credit at low interest rates to financially troubled farmers throughout our Nation. More specifically, you have asked me to comment on the proposed Farm Credit Partnership Act, H.R. 3868, and the Debt Adjustment Amendments, H.R. 4267, to the Consolidated Farm and Rural Development Act.

First, Mr. Chairman, I am encouraged by the attention being given to the concept of using guaranteed loan programs to meet specific farm credit needs. The Farmers Home Administration, as "a lender of last resort," is committed to moving toward an all guaranteed program. The legislation before us, to a large extent, is a recognition that credit from the private sector is available even to hard-pressed farmers if they can show a chance of success and if the credit risk can be shared.

Having said that, let me quickly add that, because of recent changes in Farmers Home programs and funding, I do not believe that further legislation in this field is necessary.

In recognition of the fact that in the long run, guaranteed lending is less expensive to the Government, Congress increased fiscal year 1986 appropriations for Farmers Home guaranteed loans from $1.1 billion in fiscal year 1985 to $2 billion this year. As of last Friday, April 4, Farmers Home had guaranteed over 4,825 farm loans for a total of $513.7 million so far this fiscal year. So, it is going.

That compares with 1,767 guarantees last year, for $220.5 million, at the same time last year. Last year, fiscal year 1985, was the first year that guaranteed loans have played a significant role in Farmers Home Administration's farm lending. Guarantees reached $1 billion for the first time in the history of our agency. In 1984 farm loan guarantees amounted to $443 million; the year before that, some $70 million. So, you can see it has indeed been growing.

We have great expectations. I have great expectations for guaranteed lending this year, especially since the private lending institutions are showing, I think, even greater interest in the program. Farmers Home has lined up some 2,200 approved lenders throughout the Nation. These lenders are aware of Farmers Home requirements. They have agreed to handle much of the guaranteed loan processing work, using their own documentation, not our documentation, thereby, I think, reducing paperwork that is normally required in that type of a loan.

In many parts of the country, independent banks and the Farm Credit System lenders are beginning to recognize the advantages of guaranteed loans for their hard-pressed customers.

Before I go on, I would really like to publicly acknowledge my appreciation to those Members of Congress who have helped set up information meetings between our people at Farmers Home and the local lenders throughout the United States to discuss the mutual benefits of guaranteed loans. Believe me, that assistance has been invaluable.

In other areas of the country, there is still a good deal of work to be done, I think, to convince local lenders that there are benefits to guaranteed loans. It has not been universally embraced throughout the United States as a panacea for all our ills. We do strongly suspect that persistent negative views that we are picking up are

based on isolated adverse experiences. In our early attempts at the guaranteed program, I have heard that we indeed picked too many nits as we went along the line. We are trying to overcome that.

That system has been greatly improved. For instance, recent regulations allow a line of credit to be established through a guaranteed loan program, permits the use of guaranteed loans for refinancing purposes, allows multinote packaging for sale in secondary markets, and provides for settlement of loss claims prior to complete liquidation of that debt.

Farmers Home has agreed to shorten the turn around time between application by the lender and the loan decision by our agency. I think that is happening.

We have been working hard to get the word out on the improved guaranteed loan program. In addition to the kinds of meetings with bankers I mentioned earlier that you people in Congress have set up for us, we have done a number of teleconferences and videotapes on the subject to our fellow lenders throughout the Nation.

The American Bankers Association, I think, was especially helpful in producing and distributing the interview video type of program that went to 14,000 members. That answered many of the questions that I think were posed by those bankers.

We are going to continue to promote the concept of the guaranteed loans wherever we can. We expect that even reluctant lenders will ultimately, I think, become more involved as the benefits of our program become more evident to them.

The interest buydown program, mandated by the 1985 farm bill went into effect March 18. The first interest rate reduction agreement took place a couple of weeks ago in Iowa. We now have another one going in Arkansas and another one in Wisconsin. So, that is beginning to take hold. It is really too soon to have real solid evidence of the eventual success of that program. But there does appear to be a great deal of interest on the part of our banking friends building in that program.

That program offers a 2-percent buydown shared with the lender. It's a program that most private lenders were advocating last year, when we talked about our debt adjustment program and when we initiated the program. So, we are doing really what they asked us to do.

As I indicated, Mr. Chairman, we expect the Farmers Home program to grow in our guaranteed sector. The interest rate buydown program, we think, is going to be successful. These programs, in addition to our direct lending, should be sufficient to meet the credit needs during our fiscal year 1986 period.

For these and other reasons, we recommend against creating a new layer of bureaucracy to accomplish what we think Farmers Home is already doing. For the most part, the proposed Farm Credit Partnership Act and the Debt Adjustment Amendments are redundant and could in fact, we think, impede progress toward a greater use of guaranteed funding.

The FmHA interest buydown program is a reality. It is happening. It is already here today. It is in operation. There is nothing to prevent States from offering an additional interest rate reduction to lenders if they choose to do so. We are willing to work with them. The Farm Credit Partnership Act could require an entirely

new and, we think, unneeded structure within the USDA and the States to achieve Federal-State lender cooperation.

Among other problems, I think it would, in my estimation, create an accounting nightmare, which we don't need.

A major concern is the cost of the proposed buydown system. The Federal Government would be called upon to contribute $600 million to the States for each of the 3 years of the program. In addition, the Federal Government would pay one-half of all State administrative costs. It appears that that total cost could run close to $2 billion for the next 3 years. I think that's unconscionable.

In contrast, the farm bill provided $490 million to Farmers Home over the next 3 years to accomplish, we think, the same goals. Our first year allocation for the program is $114.8 million. We project that those funds could generate as much as $5.7 billion in guaranteed farm loans.

The loan principal reduction features of title III of H.R. 3868 appear to be more restrictive than our current Farmers Home procedures. One of the major differences is that the guarantee could not be paid out unless the lending institution goes under, unless that lending institution is completely liquidated. We presently make a preliminary settlement prior to liquidation. That is an important and attractive feature for our participating lenders.

Mr. Chairman, I think for these and other reasons, we recommend against the passage of that proposed legislation. I, too, would join my associates here in answering any questions you might have.

[The prepared statement of Mr. Clark appears at the conclusion of the hearing.]

Mr. STENHOLM. Thank you, Mr. Clark.

Mr. Coleman.

Mr. COLEMAN. Mr. Chairman, I am going to ask something I have never asked before, and that is for an additional 5 minutes on top of the present 5 minutes, if my colleagues would bear with me.

Mr. STENHOLM. Without objection.

Mr. COLEMAN. Thank you, Mr. Chairman. My remarks mainly are going to be directed at Mr. Clark. I am somewhat sorry that he was not here earlier in the day. I recognize he was also testifying at other committees.

There is no ambiguity, I think, from the testimony we have received that we are in the middle of a financial credit crisis of the first magnitude. Spring planting is here. Farmers, at least in my State of Missouri, don't know whether they will be receiving the operating loans they need this year to put in their own crops. To me, this is an intolerable situation and, in many cases, completely unnecessary.

I am most deeply concerned about the numerous and continuing problems with programs operated by the Farmers Home Administration in the State of Missouri. First, the State Director decided to distribute direct operating loans on a county-by-county basis. Such a distribution, with no provision for a State pooling fund, resulted in pockets of credit shortages in some areas of the State while there were actual surpluses in other areas of the State and other county Farmers Home offices.

This particularly penalized counties in north Missouri, whose needs exceeded their allocations. By mid-February, the counties' allocations were completely exhausted, while statewide, there was shown a $20 million unobligated fund balance. So, at my urging, the State pool was finally created to provide funds to counties where allocations had been exhausted. But I am afraid that help may be too late for hundreds of farmers who were turned away during that period of time that those county offices were out of funds.

As of April 7, 56 percent of the additional $700 million which the administration transferred into the direct operating loan program was already allocated nationwide Because of our State's Farmers Home Administration distribution policy, Missouri did not receive its first allotment until just yesterday, April 8, when we received $2.4 million, which to me is a drop in the bucket as far as I am concerned.

I am also angered. I am frustrated by the failure of the Farmers Home Administration Guaranteed Loan Program and its administration in my State. In late February, statistics indicated that Missouri's Guaranteed Loan Program was far behind those of its neighboring States. At that time, Missouri's participation was 3 percent of its allocated funds, while Kansas had 36 percent, Iowa 43 percent, Oklahoma 75 percent, and Nebraska at 84 percent. So, on February 28, I did, as you recommended in your testimony, took it upon myself to meet with our Farmers Home Administration people in our State office, along with farm credit representatives from both commercial lenders and the Farm Credit System in order to try to get this guaranteed program working for our State.

At the meeting, lenders told me and told the Farmers Home Administration that the officials in Missouri were more rigid in their interpretation of lending practices and guidelines than they were in their counterparts in the surrounding States. The Missouri Director told me and the lenders at the meeting that he would be more flexible and would go that extra mile in making the program work in Missouri.

Following that meeting, I wrote to 130 lenders in our State, urging them to use the guaranteed loan program and emphasizing the cooperation that they would have and that would be necessary for them as well as for the Government to make these loans work for spring planting. Since then, I have heard from a number of bankers in my district and phone calls and letters telling me essentially the same story. I would like to have this subcommittee and Mr. Clark listen to at least one of those letters that I am going to share with you now.

This is in response to my letter again trying to make this program work: "Received your letter dated March 5, asking for our cooperation with the State Farmers Home Administration in order to make a federally guaranteed loan program a success—he writes. I noticed in your letter that you state the Missouri State office will go the extra mile to make the guaranteed program work. I am telling you here and now, Mr. Coleman, that is a joke. Our farm lending officers have just returned from a meeting with officials from the Missouri State office that was held in St. Joseph, MO"—in my district—"and they tell us to forget the guaranteed loan program.

It is cumbersome. It is unworkable, and it puts stress and paperwork on the banks. Being in the northwest part of Missouri, we have occasion to deal with two Iowa Farmers Home offices. We are currently involved in doing guaranteed programs with these offices as their rules and regulations are far less rigid and restrictive."

Another banker said that he had 9 to 10 guarantee applications pending since January. He said that Farmers Home officers in Missouri would look at an application and kick it back because something was on the wrong line or the T wasn't crossed or the I wasn't dotted.

Now, it seems strange to me that the program is flourishing in our neighboring States. In Nebraska, Iowa, Kansas, Oklahoma, and Minnesota the participation rate in the guaranteed program is respectfully 75 percent, 63 percent, 43 percent, 84 percent, and 71 percent, as of April 4. Missouri, in comparison, has gone up all the way to 10 percent. At the same time, Nebraska has received almost a 100-percent increase in their allocated funds and have already obligated those in the meantime.

So, we are told by you and others in the offices here in Washington that these programs are going to work. But they are not working, Mr. Clark, they are not working, I repeat, in the State of Missouri.

When you've got the same banker making guaranteed operating loans in Iowa but not in Missouri, it's pretty clear that the problem lies at the doorstep of the Farmers Home in our State and not at the bank's door.

Missouri is out of step with the rest of the Midwest. Therefore, there is no excuse, while other States can utilize these programs that come to a dead standstill in Missouri. In the Missouri State Farmers Home office, they say the problem is not with the county supervisor. And I don't think necessarily that it is, because a large majority of these people are working under very difficult circumstances. But I am disturbed by reports of some unresponsive, arbitrary, and even abusive county supervisors.

While one situation in Livingston County has been widely publicized, I have earlier through the years, I might add, brought to the State director's attention to review the performances of other county supervisors in my district, where I believe the complaints were justified. Yet, in each instance the State director comes back and says that these supervisors were totally competent, qualified people, but maybe they do need some improvement of their communications skills.

Well, in Livingston County the communications skills are so poor apparently that the farmers have grown so frustrated that they are using tractors to block those offices at the Farmers Home.

Frankly, I am out of patience and agree with the banker who told me that the only way for Missouri farmers to receive any benefit from the Farmers Home programs is a complete change of personnel and/or philosophy at the State level. It seems to me that we have given the State Farmers Home Administration director the funds, the tools, and all the time necessary to make these programs work to the benefit of Missouri farmers; but we are out of time. The Farmers Home Administration's State director is not working up to the standard I believe he should. We must put emergency

measures into effect and get someone running the program so it works for the farmers, not against them.

If the present State administrator can't meet the crisis, then it's time for him to leave and let someone else take over who can do the job. Therefore, Mr. Clark, I am asking you as the Administrator of this program to do the following.

One, replace the current director of the Farmers Home Administration State office. Two, within 48 hours dispatch a competent, experienced, high-level troubleshooter to take charge of the Farmers Home Administration office in Missouri. Three, dispatch to Livingston County and other troubled counties the personnel necessary to untangle the apparent mess which now exists. Fourth, design a crash plan to get Farmers Home programs working for Missouri farmers to make up for what they have lost and suffered as a result of current mismanagement problems and practices.

Mr. Clark, I do not hold you personally responsible for all of these problems in the State. You are new to the program. You are new to the Government. Frankly, I have been fairly impressed with your management and your testimony before our committee before last month. I know that you care. I know that President Reagan cares about our farmers. I care deeply for our farmers, too, and our State. Our farmers know that there is less money for their problems this year, and you alluded to that. What they cannot accept and what I cannot accept is the fact that in Missouri the Farmers Home Administration is not utilizing and making work for the farmers the money that is available.

So, there is really no time to waste to see if the State can get back on track or that we can boost them up again and have more conferences or some more seminars or some more telephone calls. It seems to me that we have to take these emergency steps today. That is why I am utilizing this forum and these definite suggestions for you to take and to follow at my request.

If you have a response, I would be happy to entertain one. You may feel that you don't want to.

Mr. CLARK. Mr. Coleman, I am terribly disappointed about the report you are giving me. I will tell you, I am one jump ahead of you in one of your requests. We indeed have sent a team to Livingston. We indeed have that response back from that investigation team. We are doing some changes in that office, not of the county supervisor. I don't think he should be run out of town because of tractors parked in front of the office. But we are making some reviews of some of those loans in that situation. So, I think we are a little ahead of you on that part of your problem.

We are, I think, perhaps putting more money out there. We have now put over $57 million out in your State. We gave the State about $2.5 million today, yesterday I think it was 860-some thousand. So, I think we are responding to the State director's request for additional funding.

It is kind of difficult to compare one State against the other, you know. Are your conditions the same as they are in some of those other States? I am sure you are aware of that as well. We try to be responsive to the unique needs of those States.

I will certainly work with you on the various situations you brought up. I will be happy to talk with you further about it.

Mr. COLEMAN. I appreciate that.

Let me say in regard to the Chillicothe, Livingston County situation that your review team has come in. Press reports indicate that this supervisor may have had "attitude problems." It seems to me that continuing the situation there just by giving him some more training is not going to solve that particular problem, that there are going to have to be supplemental personnel sent in there to assist him because it's obvious there is a complete breakdown of trust between many farmers in that community and the Farmers Home office.

Again, there are differences between States. But when I point to the States around us, and indeed where lenders are lending in other States, and they tell me these things, you can imagine why I draw the conclusions that I have.

I thank you.

Mr. STENHOLM. Mr. Daschle.

Mr. DASCHLE. Thank you, Mr. Chairman.

I in large measure have to associate myself with the remarks of Mr. Coleman. I notice that he didn't mention South Dakota as he compared Missouri to the other States. I don't have many of the figures that he has, but I have to believe that in some respects South Dakota's situation is virtually identical to Missouri's.

I recently sent a survey out to all of the people in our banking community. I think that the response was best summarized with one letter that I got, which was probably the most brief of all the letters I received. It simply said: no money, no cooperation, no certainty, no better.

I think that really does sum up as best as I can the view of the Farmers Home Program in South Dakota right now. There is a tremendous amount of frustration, a tremendous amount of uncertainty, a tremendous amount of confusion, and certainly a tremendous lack of financial support for the kind of loan demand that there is in the State right now.

As with Mr. Coleman, I certainly can't put any of the responsibility for this on you, Mr. Clark. You are going into a difficult, difficult position. I certainly don't in any way expect you to be able to solve this thing overnight. But I have three concerns that I would like you to address if you would.

First of all, a number of farmers have told me that in many cases their loans were approved as early as last January. It is now April. They still don't have any funds. They are very concerned about why that funding has not been made available.

The second thing that I get, primarily from the bankers, is that the process of the guaranteed loan application is absolutely untenable. In most cases they want to wash their hands of it. I would ask you, if you could, to give me how many, the number of the guaranteed loans that you have already allowed this year.

Finally, they are still exasperated by something we talked about earlier. I would like you to address it if you could. That is the cost of money. They are perplexed, to say the least, and very concerned about the rate of interest that many of them are being charged. This interest buydown just doesn't seem to be working. Why, if we have this interest buydown, and if it's working to the extent that you indicated in your testimony, would farmers have to be spend-

ing so much for the cost of money today? Obviously, I haven't seen any change at all. We did this survey as late as yesterday. There does not seem to be any visible indication that the cost of money has gone down, in spite of the fact that we hear the interest buydown is now in effect.

If you could address those three things, I would appreciate it.

Mr. CLARK. Mr. Daschle, I have got to tell you, yours is one of the worst States, the worst States for high interest rates from the independent bankers. I can't believe the rates they're charging out there. So, I can't respond to that. I don't know what's driving your bankers to do that.

Our rates, I know, are very attractive. We now have a 9.5-percent operating rate.

Mr. DASCHLE. I am not talking about Farmers Home. Why isn't the interest buydown working in South Dakota?

Mr. CLARK. Because your bankers don't want to give up 2 percent. I don't know, you must have some terrible shareholders out there in those banks and demanding a great return on their bottom line. But something terrible is happening in that State. I can't respond to that.

We are willing to cooperate. But they won't even come down 2 percent. They don't want to gamble 10 percent on the farmers in your part of the country. To me, that's unconscionable. They're turning their back on the very substance of our economy in that State. If those bankers go down the tube, you know, the credit cards they're issuing, the new car loans they're making, the residents in town they're making aren't worth a hoot. I really can't drive that message home. I wish you could help me in that State.

Mr. DASCHLE. I would love to. I tell you what, if the two of us can team up in some way to see that that happens, it would probably be the most unlikely couple you'll see for the rest of the year. But we'll do it.

Mr. CLARK. You know, I want to tell you, in both your States, Mr. Coleman and Mr. Daschle, we have sent teams into your States to be sure we are doing the right things in granting credit there. I am terribly disappointed to tell you that over 20 percent of the obligations, 20 percent of the credits that we are granting in your two States do not cash-flow. If we're erring in your States, it's on the side of compassion and leniency.

We have old-time county supervisors in your States that don't have tractors around their offices, they are giving the store away. They will not change the mindset that they have from years gone by, that they can come to you in Congress, turn the spigot on, and get more direct loan funds. It's hard to change that mindset that's out there. There is great compassion. They have in their own mind, in their own offices, a continuation policy: to hell with the cash flow; let's get the dollars out there. I am having a problem in both your States.

Mr. DASCHLE. In the short time that is left, let me re-ask the question. That was, could you tell me how many guaranteed loans have been made? Two, why the lag time between approval and actual availability of loan money?

Mr. CLARK. There should not be a lag time. We have a committed turnaround time for those types of loans. If there is a holdup, usu-

ally when I dig into them, it's something the bank has done. They don't give us financial statements. The appraisals aren't in there. It's not a complete package. They are trying to jam something down us for guarantee that is not documented correctly. But, you know, that's a broad statement. But the ones I looked into, that's exactly what's happened.

Guaranteed loans in your State—you're talking about farm operating loans—we have booked $22,070,000 in guaranteed operating loans in South Dakota.

Mr. DASCHLE. How many loans though?

Mr. CLARK. Numbers? I haven't got those.

Mr. DASCHLE. The figure I have—and I was hoping you could verify it—is 175. If that's the case, I am very confused. I can't imagine, with all of the demands put upon this program, that all we can say is that we have authorized and approved 175 guaranteed loans. That's preposterous. With $22 million, I sure hope it's more than 175 loans.

Mr. CLARK. It has to be.

I would be glad to furnish those numbers for you.

Mr. DASCHLE. Could you call my office or something?

Mr. CLARK. I would be happy to.

Mr. DASCHLE. I would be interested in knowing.

[The information follows:]

Farmers Home Administration Guaranteed Farm Operating Loan Allocation (thousands), Fiscal Year 1986, a copy of which is attached, reflects that South Dakota was allocated $36,813,000 in Guaranteed Farm Operating Loan funds.

The Form FmHA 389-175, "Status of Loan and Grant Obligations/Allotments or Distribution Fiscal Year 1986, as of April 16, 1986, reveals that South Dakota has made 256 Guaranteed Farm Operating Loans in the amount of $24,786,590. The state has used 59 percent of its Guaranteed Farm Operating Loan allocation for Fiscal Year 1986. A copy is attached.

Farmers Home Administration — Fiscal Year 1986
Guaranteed Farm Operating Loan Allocation (thousands)

FmHA Instruction 1940-L
Exhibit A, Attachment 1
Page 9

| States | State Basic Formula Factor | Formula Allocation | Transition Range Low | Transition Range High | Transition Amount | Base Allocation | Administrative Allocation | Total FY1986 Allocation |
|---|---|---|---|---|---|---|---|---|
| Alabama | .0152150 | 24,556 | 0 | 0 | 24,556 | 0 | 0 | 24,556 |
| Alaska | .0000000 | 0 | 0 | 0 | 0 | 0 | 200 | 200 |
| Arizona | .0044166 | 7,128 | 0 | 0 | 7,128 | 0 | 0 | 7,128 |
| Arkansas | .0193473 | 31,225 | 0 | 0 | 31,225 | 0 | 0 | 31,225 |
| California | .0335320 | 54,118 | 0 | 0 | 54,118 | 0 | 0 | 54,118 |
| Colorado | .0142900 | 23,063 | 0 | 0 | 23,063 | 0 | 0 | 23,063 |
| Delaware | .0029731 | 4,798 | 0 | 0 | 4,798 | 0 | 0 | 4,798 |
| Maryland | .0100994 | 16,300 | 0 | 0 | 16,300 | 0 | 0 | 16,300 |
| Florida | .0121931 | 19,679 | 0 | 0 | 19,679 | 0 | 0 | 19,679 |
| Georgia | .0176606 | 28,503 | 0 | 0 | 28,503 | 0 | 0 | 28,503 |
| Hawaii | .0036094 | 5,825 | 0 | 0 | 5,825 | 0 | 0 | 5,825 |
| W. Pac. Terr. | .0000000 | 0 | 0 | 0 | 0 | 0 | 200 | 200 |
| Idaho | .0132404 | 21,369 | 0 | 0 | 21,369 | 0 | 0 | 21,369 |
| Illinois | .0575895 | 92,945 | 0 | 0 | 92,945 | 0 | 0 | 92,945 |
| Indiana | .0350601 | 56,584 | 0 | 0 | 56,584 | 0 | 0 | 56,584 |
| Iowa | .0722626 | 116,626 | 0 | 0 | 116,626 | 0 | 0 | 116,626 |
| Kansas | .0376933 | 60,834 | 0 | 0 | 60,834 | 0 | 0 | 60,834 |
| Kentucky | .0330097 | 53,275 | 0 | 0 | 53,275 | 0 | 0 | 53,275 |
| Louisiana | .0150860 | 24,348 | 0 | 0 | 24,348 | 0 | 0 | 24,348 |
| Maine | .0064900 | 10,474 | 0 | 0 | 10,474 | 0 | 0 | 10,474 |
| Massachusetts | .0031949 | 5,156 | 0 | 0 | 5,156 | 0 | 0 | 5,156 |
| Connecticut | .0028536 | 4,605 | 0 | 0 | 4,605 | 0 | 0 | 4,605 |
| Rhode Island | .0016893 | 2,726 | 0 | 0 | 2,726 | 0 | 0 | 2,726 |
| Michigan | .0225967 | 36,469 | 0 | 0 | 36,469 | 0 | 0 | 36,469 |
| Minnesota | .0490631 | 79,184 | 0 | 0 | 79,184 | 0 | 0 | 79,184 |
| Mississippi | .0161980 | 26,142 | 0 | 0 | 26,142 | 0 | 0 | 26,142 |
| Missouri | .0394718 | 63,705 | 0 | 0 | 63,705 | 0 | 0 | 63,705 |
| Montana | .0158561 | 25,591 | 0 | 0 | 25,591 | 0 | 0 | 25,591 |
| Nebraska | .0389508 | 62,864 | 0 | 0 | 62,864 | 0 | 0 | 62,864 |
| New Jersey | .0048890 | 7,890 | 0 | 0 | 7,890 | 0 | 0 | 7,890 |
| New Mexico | .0082061 | 13,244 | 0 | 0 | 13,244 | 0 | 0 | 13,244 |
| New York | .0202533 | 32,687 | 0 | 0 | 32,687 | 0 | 0 | 32,687 |
| North Carolina | .0271033 | 43,801 | 0 | 0 | 43,801 | 0 | 0 | 43,801 |
| North Dakota | .0234151 | 37,790 | 0 | 0 | 37,790 | 0 | 0 | 37,790 |
| Ohio | .0349690 | 56,437 | 0 | 0 | 56,437 | 0 | 0 | 56,437 |
| Oklahoma | .0265791 | 42,897 | 0 | 0 | 42,897 | 0 | 0 | 42,897 |
| Oregon | .0130411 | 21,047 | 0 | 0 | 21,047 | 0 | 0 | 21,047 |
| Pennsylvania | .0230289 | 37,167 | 0 | 0 | 37,167 | 0 | 0 | 37,167 |
| Puerto Rico | .0000000 | 0 | 0 | 0 | 0 | 0 | 475 | 475 |
| South Carolina | .0112925 | 18,225 | 0 | 0 | 18,225 | 0 | 0 | 18,225 |
| South Dakota | .0228096 | 36,813 | 0 | 0 | 36,813 | 0 | 0 | 36,813 |
| Tennessee | .0247459 | 39,938 | 0 | 0 | 39,938 | 0 | 0 | 39,938 |
| Texas | .0605189 | 97,676 | 0 | 0 | 97,676 | 0 | 0 | 97,676 |
| Utah | .0085182 | 13,748 | 0 | 0 | 13,748 | 0 | 0 | 13,748 |
| Nevada | .0046301 | 7,473 | 0 | 0 | 7,473 | 0 | 0 | 7,473 |
| Vermont | .0053261 | 8,596 | 0 | 0 | 8,596 | 0 | 0 | 8,596 |
| New Hampshire | .0051345 | 8,287 | 0 | 0 | 8,287 | 0 | 0 | 8,287 |
| Virgin Islands | .0000000 | 0 | 0 | 0 | 0 | 0 | 200 | 200 |
| Virginia | .0181192 | 29,243 | 0 | 0 | 29,243 | 0 | 0 | 29,243 |
| Washington | .0140718 | 22,711 | 0 | 0 | 22,711 | 0 | 0 | 22,711 |
| West Virginia | .0043858 | 7,078 | 0 | 0 | 7,078 | 0 | 0 | 7,078 |
| Wisconsin | .0397636 | 64,175 | 0 | 0 | 64,175 | 0 | 0 | 64,175 |
| Wyoming | .0055205 | 8,910 | 0 | 0 | 8,910 | 0 | 0 | 8,910 |
| State Totals | 1.0000000 | 1,613,925 | | | 1,613,925 | 0 | 1,075 | 1,615,000 |
| Reserve | | | | | | | | 45,900 |
| Total | | | | | | | | 1,660,900 |

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FORM FmHA 389-1-TS
REVISED 2-17-76

UNITED STATES DEPARTMENT OF AGRICULTURE
FARMERS HOME ADMINISTRATION
FINANCE OFFICE

REPORT CODE 205C
PAGE NUMBER 10

1280.172
FARM OPERATING LOANS

STATUS OF LOAN AND GRANT OBLIGATIONS/ALLOTMENTS OR DISTRIBUTION
FISCAL YEAR 1986 AS OF 04/09/86
(IN TENS OF DOLLARS)

| | DISTRIBUTION | NO OF LOANS | INITIAL OBLIGATIONS | CUMULATIVE NO OF LOANS | SUBSEQUENT OBLIGATIONS | TOTAL LOANS | TOTAL OBLIGATIONS | UNOBLIGATED DISTRIBUTION |
|---|---|---|---|---|---|---|---|---|
| PENNSYLVANIA | | | | | | | | |
| REGULAR | | 12 | 434.15 | 35 | 1,005.74 | 47 | 1,439.89 | |
| YOUTH | | 7 | 10.86 | 1 | 4.30 | 8 | 15.16 | |
| TOTAL | 7,480.00 | 19 | 445.01 | 36 | 1,010.04 | 55 | 1,455.05 | 6,024.95 |
| LIMITED RESOURCE | | 72 | 3,720.67 | 335 | 6,327.43 | 407 | 10,048.10 | |
| TOTAL | 11,221.00 | 72 | 3,720.67 | 335 | 6,327.43 | 407 | 10,048.10 | 1,172.90 |
| TOTAL INSURED LOANS | 18,701.00 | 91 | 4,165.68 | 371 | 7,337.47 | 462 | 11,503.15 | 7,197.85 |
| GUARANTEED FARM OPERATING LOANS | | | | | | | | |
| REGULAR | | 6 | 450.97 | 4 | 257.00 | 10 | 707.97 | |
| TOTAL GUARANTEED LOANS | 34,194.00 | 6 | 450.97 | 4 | 257.00 | 10 | 707.97 | 33,486.03 |
| RHODE ISLAND | | | | | | | | |
| TOTAL | 261.60 | | | | | | | 261.60 |
| LIMITED RESOURCE | | 2 | 63.20 | 2 | 62.59 | 4 | 125.79 | |
| TOTAL | 392.40 | 2 | 63.20 | 2 | 62.59 | 4 | 125.79 | 266.61 |
| TOTAL INSURED LOANS | 654.00 | 2 | 63.20 | 2 | 62.59 | 4 | 125.79 | 528.21 |
| GUARANTEED FARM OPERATING LOANS | | | | | | | | |
| TOTAL GUARANTEED LOANS | 2,508.00 | | | | | | | 2,508.00 |
| SOUTH CAROLINA | | | | | | | | |
| REGULAR | | 85 | 4,314.01 | 92 | 4,559.28 | 177 | 8,873.29 | |
| TOTAL | 9,182.10 | 85 | 4,314.01 | 92 | 4,559.28 | 177 | 8,873.29 | 308.81 |
| LIMITED RESOURCE | | 78 | 4,875.78 | 183 | 10,323.78 | 261 | 15,199.56 | |
| TOTAL | 17,887.04 | 78 | 4,875.78 | 183 | 10,323.78 | 261 | 15,199.56 | 2,687.48 |
| TOTAL INSURED LOANS | 27,069.14 | 163 | 9,189.79 | 275 | 14,883.06 | 438 | 24,072.85 | 2,996.29 |
| GUARANTEED FARM OPERATING LOANS | | | | | | | | |
| REGULAR | | 40 | 3,119.79 | 7 | 624.54 | 47 | 3,744.33 | |
| LINE OF CREDIT | | 1 | 107.00 | | | 1 | 107.00 | |
| TOTAL GUARANTEED LOANS | 16,767.00 | 41 | 3,226.79 | 7 | 624.54 | 48 | 3,851.33 | 12,915.67 |
| SOUTH DAKOTA | | | | | | | | |
| REGULAR | | 101 | 2,584.59 | 187 | 3,692.11 | 288 | 6,276.70 | |
| YOUTH | | 1 | 5.80 | | | 1 | 5.80 | |
| TOTAL | 10,065.60 | 102 | 2,590.39 | 187 | 3,692.11 | 289 | 6,282.50 | 3,783.10 |
| LIMITED RESOURCE | | 150 | 5,608.24 | 745 | 15,720.38 | 895 | 21,328.62 | |
| TOTAL | 22,599.40 | 150 | 5,608.24 | 745 | 15,720.38 | 895 | 21,328.62 | 1,272.78 |
| TOTAL INSURED LOANS | 32,665.00 | 252 | 8,198.63 | 932 | 19,412.49 | 1,184 | 27,609.12 | 5,055.88 |
| GUARANTEED FARM OPERATING LOANS | | | | | | | | |
| REGULAR | | 141 | 14,864.64 | 30 | 2,250.11 | 171 | 17,114.75 | |
| DEBT ADJUSTED | | 9 | 1,437.00 | 1 | 85.50 | 10 | 1,522.50 | |
| LINE OF CREDIT | | 26 | 2,138.42 | 20 | 1,295.30 | 46 | 3,433.72 | |
| TOTAL GUARANTEED LOANS | 33,868.00 | 176 | 18,440.06 | 51 | 3,630.91 | 227 | 22,070.97 | 11,797.03 |

as of 4/16/86 25% 24786.59

129

129

Mr. CLARK. I am sorry. Did I miss a question or are you through?

Mr. DASCHLE. My time has expired.

Mr. STENHOLM. Mr. Gunderson.

Mr. GUNDERSON. Thank you, Mr. Chairman.

I would be interested in asking our other three gentlemen a question and give Mr. Clark a breather for a second.

A general comment made this morning consistently through the testimony when we asked how they would respond to the decisions that had been made by the FDIC, the Comptroller of the Currency, et cetera, regarding forbearance of capital, FASB 15, et cetera, they are concerned whether or not this is going to be carried out. They said if all of this is implemented with the regulators out in the field that it will be very, very helpful. They indicated that there is no such evidence to date.

I would be interested if any of you could comment and assure the subcommittee of what steps you have taken to carry this message out to your inspectors, your regulators in the field, and to make sure that what you have done here at the Federal level in regulation actually does occur.

Mr. DOWNEY. I would start off by saying on Good Friday—it may have been a week ago Friday—we worked on about a 47-page circular with attachments that was printed and is being sent to 4,900 banks. I believe that has been in the mail. On Easter Monday we telecommunicated to our district offices that same package.

We have mailed to our 2,000-plus examiners that same package. So, we have distributed the whole program of capital forbearance, FASB 15, and what have you. And it is organizationally with each of us in the senior management in the Comptroller's office, to carry out that program.

Mr. GUNDERSON. Have there been any kind of training sessions with your regulators to make sure that this does occur, when they go out there from one bank to another?

Mr. DOWNEY. The major part of the program is capital forbearance. Capital forbearance is a program which will probably be between our field and district offices and the banks, as it has been even before capital forbearance. The bank would come in to discuss their capital position, where they are going, and what have you; and that plan would be approved. That could happen tomorrow. FASB 15, we sent out a circular 1 year ago. FASB 15 has been there since June 1977. Most of our examiners are familiar with it except maybe some of the recently hired examiners may not be. So, there's no need for additional training there, but it continues to be a part of our regular training program.

Mr. GUNDERSON. Mr. Meadows, can you comment at all on this?

Mr. MEADOWS. We mailed information to both our regional offices, which will be distributed to field examiners, as well as each State nonmember bank on March 27. With respect to capital forbearance, banks which think that they may qualify for the forbearance need only to apply to the regional office.

We have also sent out material on FASB 15. We don't feel that we need training sessions at the present time. But if we detect a need, we will have those sessions.

Mr. GUNDERSON. Am I correct that all three of you oppose loan loss amortization?

Mr. MEADOWS. That is the FDIC's position, yes.

Mr. DOWNEY. Yes.

Mr. TAYLOR. Yes.

Mr. GUNDERSON. Mr. Clark, can you give us a quick summary of the exact numbers? I heard your testimony but I don't recall that you said exactly how many dollars in operating and guaranteed loans, or direct and guaranteed operating loans are authorized and have been distributed at this point in time. In other words, what percent of the money for crop year 1986 is out there in terms of actually in the hands of a guaranteed loan or a direct loan?

Mr. CLARK. In our direct operating loan for the fiscal year, we have obligated $1.6 billion. About 73 percent of our $2.2 billion funds for direct operating loans have now been booked. You recall we had the $700 million that was transferred under the President's authorization, from our emergency loan fundings into the direct OL Program. Of that $700 million we have $337.7 million yet to be allocated to those States.

Again, we have to be very careful about that. There are indeed some emergencies most likely that will happen in this country. We need, I think, to be very cautious of preserving what emergency funds we have yet available.

Mr. GUNDERSON. Just a second, a clarification. In the direct loans you had $1.6 billion or $2.2 billion authorized?

Mr. CLARK. $2.2 billion authorized. It includes the $700 million.

Mr. GUNDERSON. That includes the $700 million.

Mr. CLARK. It does, it does.

Mr. GUNDERSON. OK. Out of the $1.6 billion originally authorized under direct loan, 73 percent of that has been obligated——

Mr. CLARK. No; 73 percent of our whole funding program. We have pumped the $700 million in there as well.

Mr. GUNDERSON. Of the $2.2 billion.

Mr. CLARK. That's correct.

Mr. GUNDERSON. OK. So, you got $1.6 and $700 million, and we got $337 million yet to go, in direct loans.

Mr. CLARK. Of the $700 million, yes. Of the whole total we have about $600 million left.

Mr. GUNDERSON. OK. This is why I am asking the question. You got $337 million left to obligate under the $700 million.

Mr. CLARK. That's correct.

Mr. GUNDERSON. And you've got about $260 million left of the original $1.6?

Mr. CLARK. That's right.

Mr. GUNDERSON. That gives us a total of about $600 million yet to go.

Mr. CLARK. That's correct.

Mr. GUNDERSON. How about in the guaranteed area?

Mr. CLARK. In the guaranteed operating loans, original allocation funding a billion seven. We booked about 30 percent of those loans, $505 million. We got a billion two yet to utilize. A lot of room.

Mr. GUNDERSON. All right.

Thank you, Mr. Clark, and thank you, Mr. Chairman.

Mr. GLICKMAN [acting chairman]. Thank you, Mr. Gunderson.

Mr. Stenholm, have you asked questions yet?

Mr. STENHOLM. Mr. Taylor, Mr. Meadows, and Mr. Downey, my question goes to the three of you. I followed your testimony. I followed the previous testimony before the Banking Committee in which you talk about the proposed change in regulations, the easing up in some cases to make it more possible for agricultural banks to weather this storm, and agree with most if not all of the suggestions.

My concern is that, just as we have heard time and time again today whether we're talking about Farmers Home or whether we're talking about anything that is happening in regard to the farm program, that we're saying one thing in Washington but it's not getting down to the grassroots level. Within the last 30 days, I had a circumstance with a small rural bank in my district in which they had an examination. They had three loans classified. They were agricultural loans that had had interest only paid for the past 2 or 3 years, interest only. They were classified. As the individual banker brought those individual farmers in to his bank and said, I got a little problem, we're going to have to work something out, all three of them sat down and wrote out a check for their loan, on another bank.

Now, I assume this was before the word has gone out on the change in this capital requirements, et cetera. But it is not so much a specific question to you as the fact that we continue to hear from the banking—I do, from my district—from the banking level, not wanting to say ease up too much, in a substantial amount of agreement with your testimony before this subcommittee today about some of the proposals that we are making and saying, let's not go too far, because it'll get us in trouble, too, while at the same time, expressing concern that the examiners who come to that bank do not have a fundamental understanding of agriculture and do not have a fundamental understanding of banking and are not in fact doing that which you have testified today, saying that that's the new look in examination.

Mr. MEADOWS. I'll be glad to start the response to that. It is difficult for us to know the full circumstances. First of all, I would say, if the banker only had three classified loans, he did not have a very significant problem. There is no——

Mr. STENHOLM. You don't know the circumstances in this particular circuit, but go ahead.

Mr. MEADOWS. All right.

There is no requirement, in other words, the FDIC examiners, or the others, as far as that goes, do not require collection efforts on the part of the bank. That is up to the banker. Now, it could be in a situation like that full and complete information was not in the bank files. Maybe the banker didn't know that the loans could be paid in that fashion.

Obviously, in retrospect the loans should not have been classified. But what we don't know is, did the banker and did the examiner have full and complete information about that particular borrower?

Mr. STENHOLM. in all candor, the banker admitted to me that it quite possibly was a personality clash because of his personal opinion of the examiner who was in the bank. And he accepted his share of the blame of some of the things that occurred because of

the manner in which he personally felt about this particular examiner.

Also, the circumstances around this particular loan were that he owns another about five banks besides this one and has just put $2 million of additional capital into all of his ag banks, trying to keep them up. So, while it may just be three at this one bank, it was a little more serious to that individual banker.

Your comments are well taken and appreciated.

Are there any other comments? What are you doing to see that in fact the message that you bring to us is in fact getting down to the examination level?

Mr. TAYLOR. If I could just respond, you know, we have an admitted difficulty and an unevenness among training and expertise in people. We try to even that out as well as we can with training. But I would point out that, with respect to the agricultural banks, in addition to delivering the messages as clearly and as completely as possible, which we will do again next week at a meeting of all of our regional vice presidents, we have set in place a procedure whereby each agricultural bank draft examination report is reviewed by an officer or a senior person at our district bank before it is returned to the banker. That examination report is reviewed to tighten up the consistency and to make sure that the programs that we are putting in place are indeed not being frustrated by the miscommunication or the lack of experience of a new examiner.

That has worked pretty well. We continue to have a miss now and then, but we continue to operate that program.

Mr. DOWNEY. We have a similar program, but I want to speak to what we have just put out. We have the same concerns. Your points are well taken. We do have some examiners out there that may be a little bit overaggressive sometimes. We do follow up on every one of those situations that are brought to our attention.

As far as the capital forbearance program goes, the OCC has put into place a monitoring system so that every bank that approaches our office regarding capital forbearance, in the event that they are turned down, that denial will come into the Washington office subject to my review, so that it will have an additional review. We don't want to put into place a capital forbearance program and then not have it implemented in the various districts. So, we have put that into place.

I might also say, in defense of the examiners, that it is getting to be a very difficult job being an examiner out there where our problems are the greatest that they have ever been. It is getting difficult to hold on to good examiners. We do have a newness to some of our people. We are working very diligently to try to get them up to snuff like the rest of us.

Mr. TAYLOR. They're getting old fast, I might add.

Mr. STENHOLM. Thank you. My time has expired. I have some additional questions. I will wait for my other colleagues.

Mr. GLICKMAN. Mr. Evans.

Mr. EVANS of Iowa. Thank you, Mr. Chairman.

I would like to begin by visiting a moment here with Mr. Clark and to say I have the greatest respect for the efforts you have made to get control of the management of that agency to which

you're saddled and say to you that I think that in the State of Iowa at the State level things are functioning very, very well.

I would go on, however, to speak for a minute or two in more general terms on this problem of consistency of policy. I don't think there is any question that there is inconsistency of policy at the various levels of bureaucracy within the Farmers Home Administration. I think that in our State it happens to be at the country level rather than departures at the country level from the philosophy that you are proposing and the policies that you are proposing rather than at the State level.

There is absolutely no doubt in my mind that there is within your bureaucracy a very substantial number of people at all levels who have absolutely no time for the guaranteed program and who make no bones about it and have every desire to do everything they can to slow that down and go back to direct loans. They think that's the way it ought to operate in the Farmers Home Administration. I know you are trying very hard to overcome this.

My question to you is, Is it possible to overcome this? Do you have the powers available to you to take action against those people who deliberately not following the policy set forth at the national level by Farmers Home?

Mr. CLARK. Well, I've got to tell you. The transition from the private sector has been difficult for me. In my other life, I could fire people and that would be the end of it. I can't do that in civil service, I have learned. There are all kinds of appeal processes, Merit Protection Boards, and I really can't crack that whip as I did in my other life. It is frustrating. It's hard to get 12,000 people marching down the same road, let alone at the same beat. We have terrific training programs going Even 46 State directors marching to the same beat is very difficult.

I wish I could share with you some of the browbeating problems that we have gone through, just this morning, actually threatening my State directors, you know: if you don't lower this rate of approving loans without cash-flow, I have no alternative but to share that concern and disappointment with their legislators. So, I am looking to you to help me, if you will, to crack some of those whips. It's very difficult.

Mr. EVANS of Iowa. I understand that. I appreciate that very well. The only suggestion that I have, and I offer it only partially in jest: do you think it might be useful if we authorized and directed you to open a branch office in Nome, AK, with unlimited size of staff and the ability to transfer people to that office?

Mr. CLARK. That's a fine idea.

Mr. EVANS of Iowa. If I may leave that and go to the other three representatives of the regulatory agencies of the commercial banking system, there have been implemented a number of changes recently. They have been alluded to here, to make it easier for the commercial ag banks to handle their problems and to encourage them to restructure debts, and so forth. Some of those things were discussed, or variations thereof, when we were looking at Farm Credit System legislation here in the latter part of last year. At that point Treasury, for example, was not nearly as receptive to some changes of this type as they have become since the first of the year.

Do you as regulators of the commercial banking industry have any objection to trying to give those same sort of powers and flexibility now to the elements of the Farm Credit System? Do you think they have the power to do that under present law through the FCA, or does that require legislation on our part? Or are there any other comments you have on that, the apparent difference that now exists to some extent between the flexibility of commercial agricultural banks and the Farm Credit System?

You don't have any objection then to extending the same powers to the Farm Credit System, one way or the other?

Mr. TAYLOR. Do you mean to extend the powers to the FARM CREDIT SYSTEM to deal with lower capital?

Mr. EVANS of Iowa. They have that. I think we gave them that. We didn't give them some of the other things, however.

Mr. TAYLOR. The FASB 15.

Mr. EVANS of Iowa. Yes.

Mr. TAYLOR. Well, I think that, from the comments that Mr. Clark has made, that the concept of FASB 15 wouldn't be foreign to them. It sounds to me like to the extent that a loan provides cash-flow——

Mr. EVANS of Iowa. Well, we're not talking about Farmers Home now; we're talking about the Farm Credit System.

Mr. TAYLOR. I would think that the Farm Credit System would not be averse to reschedulings or whatever was needed if indeed the loan provided cash flow over a reasonable period of time to repay the loan.

Mr. EVANS of Iowa. But you don't have any objection to their having comparable power?

Mr. TAYLOR. I would not think so.

Mr. MEADOWS. I don't know on what basis we would have to object.

Mr. CLARK. Could I make a suggestion? Give them more power. It will take a little heat off of me.

Mr. EVANS of Iowa. Mr. Chairman, may I have another minute?

Mr. GLICKMAN. The gentleman is recognized for 1 additional minute.

Mr. EVANS of Iowa. Again to the three regulators of the commercial banks. The point has been made by a number of bankers and representatives of the industry that there is a great need for a secondary market, a guaranteed secondary market of long-term agricultural debt to the commercial agricultural banks, guaranteed in some manner by the Federal Government in somewhat the same manner as we guarantee and market on the secondary market residential housing debt.

What observations do you have on the desirability of one way or another providing that kind of a secondary market capability to agricultural banks on sound agricultural loans at this point in time?

Mr. DOWNEY. Speaking for the Comptroller's office, the Comptroller's office is very much in favor of that. Mr. Clark has spoken to that in public hearings. One of the things we are looking at is ways in which we can help agricultural banks diversify their portfolios. One of the ways in which that would occur is through a secondary market for their ag loans.

Mr. EVANS of Iowa. Thank you, Mr. Chairman.

Mr. GLICKMAN. Thank you.

Mr. Stallings.

Mr. STALLINGS. Thank you, Mr. Chairman.

I was interested in Congressman Daschle's comments on the number of loans in South Dakota. I am not sure if you are aware, but in Idaho we have had 24 guaranteed loans this last year, which does not speak very well for that particular program.

Mr. Clark, I really hate to heap additional criticism on your shoulders today. But having problems with the Farmers Home county supervisors and State directors is not unique to Missouri. I have received petitions from nearly 400 farmers in my State who are demanding the resignation of the Idaho State director. Are you aware of those petitions? What, if anything, has been done to investigate that problem?

Mr. CLARK. My only awareness is from the news media, which have called me about it. I have not seen that in any form at all. I am waiting to be prodded with that. So, I am standing by.

Mr. STALLINGS. Very good. Thank you.

When you appeared before this subcommittee on February 6, I asked you about the status of the new regulations defining the family farm for purposes of borrowing from Farmers Home and for qualifying for disaster loans. You said at that time that these regulations were still being reworked. We are 2 months later down the road. Most of the disaster loan applications are still on hold in my State.

Again, what progress has been made in issuing new family farm regulations? Specifically, what have you thought of the guidelines that I submitted on February 12 for defining a family farm, in my opinion, that I think would be very equitable to both farmers and American taxpayers?

Mr. CLARK. Again, those regulations are imminent. They should be out very, very soon. In fact, we have letters in preparation to all the committee members saying: Here's what we have in mind; it's going to interim rule, going out for comments as well; what do you think about it?

One of the major benchmarks in that proposed family definition in addition to blood or marriage relationship, in addition to blood or members of families getting together with entities that are eligible for coverage is a limit of gross farm income. We are proposing $500,000 as gross farm income. We are going to ask you about that. That is one of the big benchmarks. I think yours was higher than that, as I recall.

Mr. STALLINGS. Yes; it was.

Mr. CLARK. $750,000?

Mr. STALLINGS. I was asking $750,000. I think that's imperative for the western farmers.

You said in your testimony that you think that new Farmers Home interest rate Buydown and Loan Guarantee Programs are sufficient to meet the credit needs during fiscal year 1986. Is this situation really true everywhere in the country, particularly in States like Idaho, which have made very few guaranteed loans? As I said, there were only 24 so far in the State. I guess you wouldn't need much money if we're only going to make 24 or 25 loans per State.

Mr. CLARK. No; we wouldn't.

We will probably use those funds from your State by reallocating to another State that has greater demand for guaranteed funds.

I have to tell you. It's going to be a close, tight, squeaky call this year to get through with what we've got. But we need the cooperation of the other lenders. We can't do it alone. In some States we are the primary lender. Fifty-five percent of the credits booked in Louisiana are Farmers Home. That's ridiculous. We cannot go on that way. We need the help of the other lenders, and in your State as well. I ask for your help in that direction.

Mr. STALLINGS. Thank you.

Mr. GLICKMAN. Thank you.

Mr. Franklin.

Mr. FRANKLIN. Thank you, Mr. Glickman.

Mr. Clark, I am going to direct my questions to you and point out to you that in my district 65 percent of the credit penetration is with you and your agency.

I want to sincerely thank you for the efforts on Mississippi's behalf in trying to put some pressure on getting these loans out. You know firsthand about it because we have had a credit team. We have had a homestead team. We've had every team that you can imagine go down there from your office. I thank you for that and for your cooperation.

However, that was yesterday. Today I understand that there are $11 million worth of loans sitting there waiting for you to let go today. Did you sign that today, that additional $11 million that we've got up there?

Mr. CLARK. It's $9.9 million, and I did not. I've got some questions about your fair State that I need to talk to that director about. That is, again, approving almost 10 percent of the loans that don't cash-flow. I need a better "scout's-honor" that's not going to happen anymore. So, that's really what we're negotiating with your State director about.

Mr. FRANKLIN. I understand that, but I want you to realize that the negotiations with the State director are causing severe problems for the particular farmer who does happen to qualify and has been through the process and whose loan is sitting on your desk during a negotiating process with the State director who meets all the requirements and who just got a rain and who needs to plant that cotton tomorrow in Mississippi. And he can't do it without that money that you've got held up on your desk.

The second thing I want to ask you about is this. When can we expect the homestead regulations providing those farmers who are not being financed this year in my district to come in, have their land surveyed, keep their house, finance for 35 years on a separate note, and have at least a place to live, coupled with the debt settlement regulations? When can we expect those regulations to be promulgated and in the field and working, sir?

Mr. CLARK. I wish I could give you a date. I can't. But I will tell you that it's very immiment. We are looking for a publication date within the next 2 weeks. But the regulations are in the field on the homestead provision. We are taking applications, especially in your State. We did a good intensive study of that: get in line; here's the application; when it's ready, we'll do it with you.

Obviously, some of that property is going to stay there as it is. We are not going to disturb those tenants. We're not going to file foreclosures on them while all of this is happening. So, I think they can be pretty confident about keeping the kids in school and staying there.

We are going to be ready to sign them up when that debt settlement regulation is published.

Mr. FRANKLIN. Then I can assure those farmers who happen to be in that particular situation and who are waiting with baited breath the regulations, that in the interim adverse action is not going to be taken, and they will be given a chance to make application for the homestead provisions and for the debt settlement?

Mr. CLARK. Well, now you're pinning me to the wall.

We have some dishonest borrowers, even in Mississippi. We've got to be careful about that, you know. The dishonest ones, we might have a problem with. But of those farmers who have worked, and through no fault of their own, are really having a failure, we're ready to offer them that opportunity. So, I would say yes.

Mr. FRANKLIN In the normal case then, in 1986, they can have some assurance that those regulations will be in place, and in the interim that no adverse action will be taken as far as foreclosure is concerned?

Mr. CLARK. Well, part of that is the debt settlement. They either have to agree—you know, here are the keys to the gate; we give up; take my land; leave me the house. We can do that. If they are not cooperative and won't do it, we do have to go through the foreclosure proceedings.

Mr. FRANKLIN. As I think you understand, we have got several that are already standing in line to hand you those keys in Mississippi.

Mr. CLARK. We'll do it.

Mr. FRANKLIN. The second question: In the debt settlement regulations—and I know that you're negotiating on those now—are you aware that—I am sure you are—that the State only h[illegible] a $25,000 limit——

Mr. CLARK. I am.

Mr. FRANKLIN. On what they can do without [illegible]ng to burden you with the problem? It would appear to me t[illegible]if you increase that limit, that you could give the State director somewhere substantially more than that, that it would save a whole lot of time in going through this process? Have you considered that? Do you have a figure in your mind as to what that State director ought to have as far as authority and debt settlement is concerned?

Mr. CLARK. My starting figure is $100,000, Mr. Franklin. So, we are going to get the authority out there to do that.

Mr. FRANKLIN. Could I double you and ask you to consider it?

Mr. CLARK. Sure.

Mr. FRANKLIN. I think that it's going to take more than that for you not to get all the ones that are applying in my district, is what I am saying to you. And then you'll be burdened with it rather than let this go on and take place through the State where they can also do it.

Again, I want to thank you for yesterday's efforts. However, the problems still continue today. We want to continue to be able to

rely on you to help us solve those problems in Mississippi with Farmers Home.

Thank you, Mr. Chairman.

Mr. GLICKMAN. I would just like to ask Mr. Downey and Mr. Meadows this. Some of the folks in my home believe that you did not take the kind of reasonable action that you are currently taking with respect to a variety of banking flexibility on capitalization and amortization of loans until the energy crisis began to hit. That is, the ag crisis was real for a long time, but that didn't seem to be enough. It took the added hit of energy problems in the central, southern, and southwest region of the country to get you to become more flexible.

I wonder if you might comment on that.

Mr. DOWNEY. I think, Mr. Chairman, if I could, we spent the latter half of last year dealing with national banks that represent 5 percent of the assets. As the Chief Examiner for the country, I spent 50 percent of my time in agricultural matters. So, there has been that concern. We work very closely with a lot of groups of people. We have traveled the country trying to really get our hands on what the problem was. We determined it was capital forbearance, and we worked with it.

When we went before the Senate Banking Committee, our proposal was strictly to agricultural banks. By the time that hearing was over, it had included energy. So, I think our efforts were directed at agriculture. We were moving to provide some assistance to those banks. Energy was something that came later. So, I don't think there is a correlation. Energy did not force this.

Mr. GLICKMAN. Mr. Meadows.

Mr. MEADOWS. I fully concur with Mr. Downey. Like Mr. Downey, I spend a great deal of my time dealing with the agricultural situation. I think the fact is that most agricultural banks have been very well capitalized over the years. They have now in the past year gotten to the point where that capital is being called upon to absorb losses and, as a result, the Capital Forbearance Program.

Mr GLICKMAN. My second question relates to the legislation which we have before us, the Panetta bill and the Bedell bill. I think you have spoken to that to some degree in your testimony. I wonder if all three of you, Mr. Meadows, Mr. Taylor, and Mr. Downey, would indicate how you feel about that proposed legislation or any other that would deal with credit forbearance and/or banking regulation changes that would require that kind of forbearance or different accounting treatment of bank assets.

Mr. MEADOWS. As expressed in our testimony, we have very serious reservations about any program that would delay recognition of losses. We have some very serious problems with that. We think that losses should be recognized currently. We think it is unreasonable for the banking industry to, in effect, put off their problems to the future. We think it would be much better for the banks to put their problems behind them.

We think the program that we have with capital forbearance will allow them to do that and still give the public, the investors, and depositors a balance sheet or a published statement that can be relied upon as being accurate.

Mr. GLICKMAN. Mr. Downey.

Mr. DOWNEY. We believe that the program in place does not require any additional legislation or laws that we would need at this point in time. We have a plan which, as we explained, capital forbearance, extending the lending limits, and FASB 15. I don't think that requires any legislation.

Mr. GLICKMAN. Mr. Taylor.

Mr. TAYLOR. I don't believe that we would resist any legislation that incorporated in the basic meaning of what we have tried to propose on a voluntary basis. But legislation that would defer losses, I think, brings up the problems of nonrecognition of the reality of the situation, and indeed could exacerbate the Government's cost as well as the farmer and the banker's problems.

Mr. GLICKMAN. The only thing I would respond to you is that it took an awful lot of congressional pressure and threat of legislative action to get you to move in these areas. I want the record to reflect that I think it was the fact that lots of folks were coming up here to Capitol Hill to say these regulators are not being very responsible in how they're treating losses; they're being too black and white, cut and dried, without reflecting the realities of what was going on there for you to even come up with what you were doing. So, there is, at least on some of us, a little bit of skepticism about where you were coming from during all this time.

Whether we pass any legislation or not, we're still going to keep the pressure on you to reflect responsibly on how you deal with the rural banking situation.

I would ask for 1 additional minute.

I just think that's very important because the energy situation is causing a doubling of the problem.

Two quick things: the secondary market issue that Mr. Evans talked about, how would you feel about setting up a Fannie Mae or a Ginnie Mae type of entity for Government-backed securities in the agricultural market, either Farmers Home securities or other kinds of securities? Some people say that is what we need to establish some liquidity in the markets.

Mr. TAYLOR. The questions of cost aside, I think that it would be a good idea, but I do think you have to face the question of what it would cost to do this and what it means in the way of increased Government expenditures.

Mr. MEADOWS. I think one other aspect should be noted, too. I am not convinced that there is a nonavailability of funds to lend on the part of the commercial banks. The banks seem to have funds to lend and do not appear to be under undue pressures from the standpoint of liquidity. But such a proposal could work very well.

Mr. GLICKMAN. It would be a permanent type of entity to deal with this at all periods of time, which has worked very well in the housing market and the Government securities market. I just think that we have never really seriously considered that recently, at least in the ag market.

One final question I would ask Mr. Downey and Mr. Meadows particularly. How many rural banks are we going to have fail this year?

Mr. MEADOWS. Mr. Chairman, so far this year, there have been 13 so-called agricultural banks which have failed. This is exactly

the same number that had failed at this time last year. At this point we don't know what effect the new programs will have on bank failures, but we feel that there still will be a sizable number, perhaps very close to the same number we had last year.

Mr. GLICKMAN. Mr. Downey.

Mr. DOWNEY. We had 30 national banks fail last year. We had eight fail in the first quarter. Annualized, that would be 32. I think the number of banks that will fail, national banks, will probably be a little bit greater than it was last year, somewhere in the thirties. Of course, most of those will be small rural banks.

Mr. GLICKMAN. Will they be banks with a lot of energy loans?

Mr. DOWNEY. I think they will be a combination of energy loans, ag loans, and what have you. It seems like the eastern part of the country seems to be in pretty sound condition. I think where our problems are are, as you well know, in the Midwest and Southwest.

Mr. GLICKMAN. Thank you very much.

Mr. Stenholm.

Mr. STENHOLM. Mr. Clark, I haven't asked you yet today, so I want to ask today the situation concerning the dispensation of the additional $600 million in direct loans and the $337 million and the extra $700 million that was transferred regarding in this case the State of Texas, which I am told has $18 million in approved loans awaiting the cash dispensation from this fund. Farmers are ready to plant. What really got my attention was my Small Business Subcommittee holding hearings last week and many of the small businesses that have been selling them, advancing them fuel, fertilizer, et cetera, are beginning to get nervous, too, now about when they might be expected to receive those funds.

Mr. CLARK. That's correct. There is $18 million in the pipe in Texas. I might tell you that, if we had allocated that $700 million to every State, as we do original allocations, you would be overdrawn. Texas has now drawn more than their share from that $700 million reserve.

We are looking at it. Again, I have some problems in Texas with the approval of loans that don't cash-flow. I have a conference call, once I leave here, with the State director about that problem.

We have been doing very well, I think, by Texas. We have got $174 million down there. We started out originally at 118 allocations. So, I think we have done very well by Texas.

I hear what you're saying. It's planting time. Those cotton growers are out there ready to go in many parts of the State. We will do the best we can.

Mr. STENHOLM. I appreciate that. I guess the problem that we have now is the farmer awaiting his funds who can cash-flow is not going to have much sympathy on you or me or anybody else for having advanced money to a farmer who cannot cash-flow. I guess that's hindsight and can't do anything about it.

We will appreciate a speedy handling all over the United States of those farmers who can cash-flow, who do qualify, where we do have the money set aside, getting the money to them. It's planting time.

Mr. CLARK. That's exactly my point. We need to be sure that State is putting forward to be funded those loans that should be funded.

Mr. STENHOLM. What States have the most problems with State banking regulations that create problems that some folks are suggesting that we solve federally but yet we have the State problems? I forget which one, Mr. Meadows, Mr. Taylor, Mr. Downey, referred to that in your testimony, saying that there need to be some changes in State regulations. What are some of the States that have got some problems that are making it difficult for us to even consider doing something federally?

Mr. MEADOWS. I think I had comments in my testimony concerning that States should take a look at laws and make appropriate changes. What we were referring to there—and it's going to be very difficult for me to name the States, because I just don't have them handy. There are a number of States which have very restrictive branching laws, which make it very difficult if not impossible for the FDIC to find a buyer in the event of a failure. As a result, we may end up with a deposit payoff as opposed to a merger which would continue banking services in a particular community.

Mr. STENHOLM. If I might interrupt you at that point, without naming States then, in those States where there is a problem, is the legislative climate within the State now to where they are looking at it? Or are the original reasons for having the law in the first place still the prevalent political attitude within that State?

Mr. MEADOWS. It's my understanding that a number of States are looking at it, although with varying degrees of success in resolving the problem.

Mr. STENHOLM. There is not a unanimous agreement on what ought to be done?

Mr. MEADOWS. Absolutely not.

There are other areas that do present problems, too. For an example, some States require other real estate, real estate acquired through foreclosure, to be written off over a period of time. In other words, the bank might be required to write off 20 percent of the book value of that real estate each year. We think States should take a look at laws like that. Our position is that banks should be permitted to carry real estate in that fashion at appraised value rather at some charged-off amount.

I think the OCC may have liberalized their regulations in that area recently.

Those are some of the things. There are other laws which prohibit corporate ownership of farms. That might limit the marketability of farms and hurt the entry into the farming business and the exit from the farming business. People might like to get out, but there's nobody to buy.

Mr. STENHOLM. Thank you, Mr. Chairman.

Mr. JONES of Tennessee. Thank you very much, Mr. Stenholm.

Mr. Evans, do you have questions?

Mr. EVANS of Iowa. I do, if I may, but I would be glad to——

Mr. JONES of Tennessee. I want you to go ahead.

I just want to apologize to the witnesses for my having been absent. I had something else that had to be done, and we had someone else here who could do this.

You are recognized.

Mr. EVANS of Iowa. Thank you very much.

I would like to speak to the three gentlemen again from the regulatory agencies. I hope you have come to understand today that there is very little connection between the rates that are charged to extremely creditworthy borrowers for short-term operating loans out there in the country and the national rates that you people look at as indicators of what is happening to interest rates in the country as a whole. I very regularly get calls the last few weeks from outstanding borrowers from the standpoint of the ability of that person to repay. Farmers that owe nothing on their land, farmers who could cash-flow 150, 160, 170 percent of any operating loan, are saying: how come is it, with the prime rate at 9 percent and the discount rate at 7 percent I am having to pay 12 or 13 percent for farm operating loans?

I think it is very important to you people, who are looking at things from the national level, to understand that, when that prime rate comes down, you aren't seeing any results like that in the country for the foreseeable future. Now, there is a lag and there always has been a lag out in the country; and I understand that. But it's more than that. I think you need to understand it.

There are a lot of banks out there that have no problems at all that are charging those kinds of rates to the prime borrowers in agriculture.

To go on from that just a little bit further, it has been noted here today that many of the ag banks across the country are very reluctant to participate at all in any agricultural financing today and even under the guarantee program. That is a major problem that faces Mr. Clark in these programs.

My question to you is, what, if any, role is there or responsibility of your agencies to see that there are not abuses of that kind out there in the country that are causing great problems for agriculture and the recovery of agriculture? Do any of you care to comment on that?

Mr. DOWNEY. I would make a statement, Mr. Evans. One of the things we were proposing and have probably every time we have had an opportunity to appear before a subcommittee here is that competition solves a lot of those problems. When you have competition of other providers of financial services willing to go in and provide those rates which you are talking about to those worthy borrowers, that is when they are going to receive them. When you have artificial barriers set up where those people cannot grant those types of credits, then you will have this what you are calling probably a higher level.

The other thing is that, if you follow the interest rates on ag loans, they don't really correlate to the way the interst rates move in the other markets. When we had very, very high interest rates in this country, in most of the ag banks they did not go up in the same relationship as other banks charged the prime credits in urban areas. So, there is that.

Mr. EVANS of Iowa. I understand that. I would like to comment on your use of the word competition, however, if I may. There are reasons why competition isn't working out there at this point. One of those is that historically the Farm Credit System has provided some strong competition to commercial banks in getting their rates down, both on short-term operating loans and to the extent that

banks are involved, which is a much lesser extent, in long-term real estate loans.

That competition does not exist today. The Farm Credit System Rescue Act that we passed recently, for the immediate future at least, and maybe for the long-term future, depending on what policy evolves in the Farm Credit System, condemns that Farm Credit System to be essentially noncompetitive compared to a lot of the commercial banks.

There is, if you will pardon the expression, to some extent a good-old-boys club within the banking industry and in the agricultural banking community. That is not unique to banks. I don't put it down there. It applies in many other industries as well. But it borders naturally, or tends to, on restraint of trade, if you will. There are an awful lot of people that are not responding competitively at this point because they are not forced to.

If I may go further, I think there are a lot of savings and loans in this country who would love to get in there and provide some of that competition. Generally speaking, they don't have the staff who are competent in lending to agriculture. I think there are a lot of insurance companies that would be delighted to get in there and provide some of that competition, if they had a retail network and the ability to do this, or a secondary market that would enable them to do this. I think it's terribly important if you want to see a recovery in agriculture, that some of these problems be addressed in one way or the other.

I would just point out to you a typical farmer's case in my district who raises corn, for example. It costs him something like 15 or 16 cents a bushel for the seed; something like 17 or 18 cents a bushel for the chemicals; maybe 25 cents a bushel for the fertilizer; maybe 10 cents a bushel for the fuel. But what's his cost of debt service at this point if he's got $1,000 an acre borrowed against that land? It's on the order of $1 a bushel. It overwhelms all other costs.

It is a terribly important element in how we get out of this mess in agriculture. I think that the regulatory agencies of the commercial banks need to look hard at the possibility of some unwarranted abuses. I don't know what you do about it, but I think you ought to be aware that, in my judgment, they are there and it ought to be addressed. Maybe it isn't within your power at this point to do so.

Thank you, Mr. Chairman.

Mr. JONES of Tennessee. Thank you very much, Mr. Evans.

Mr. Franklin, do you have questions?

Mr. FRANKLIN. No, Mr. Chairman.

Mr. JONES of Tennessee. I suppose that concludes all the questions except one.

I wanted to ask Vance Clark. I am sorry. I read your testimony but I was not here. Have you had an opportunity for your shop to make a cost estimate on H.R. 3868?

Mr. CLARK. Refresh my memory, the number again, Mr. Chairman?

Mr. JONES of Tennessee. It is H.R. 3868.

Mr. CLARK. That's the one we testified today?

Mr. JONES of Tennessee. Yes.

Mr. CLARK. No, we have not.

Mr. JONES of Tennessee. You have not?

Mr. CLARK. No.

Mr. JONES of Tennessee. Would you mind doing that? Can you do that and let us know your cost estimate before we take any further action?

Mr. CLARK. I will be happy to do that.

Mr. JONES of Tennessee. I appreciate it very much. I think we ought to know that before we start consideration of the bill.

Would you agree?

Mr. FRANKLIN. Yes.

[The information follows:]

We have learned that H.R. 3868 is considered a "dead bill" and no costs estimates are required.

Mr. JONES of Tennessee. If there are no further questions——

Mr. EICKHOFF. Sir, I have one. Can a farmer from Indiana say just a very short sentence?

Mr. JONES of Tennessee. Yes, sir.

If you will just wait a moment, we will take you as the next witness.

I want to thank you very much, gentlemen, for being here. I am sorry I missed your testimony. I will read it anyway. I am sure it will contribute greatly to this hearing. I hope what Mr. Evans said will be looked at in the final moments of his testimony there, just a few moments ago.

You are dismissed.

Now if the other gentleman will come forward.

## STATEMENT OF NORMAN EICKHOFF, FARMER, CARTHAGE, IN

Mr. EICKHOFF. My name is Norman Eickhoff. I am a farmer from Rush County, IN, Carthage. What I have in mind, along with other people, is a good solution to the farm crisis. It should end it. The farmers, ranchers and growers of this great country have no say in what we get for what we produce. Everybody else can put a price tag on it; we can't. We have got to get that right, gentlemen, or we're done as family farms.

We would be happy to work with Congress, the administration. I have done several things along those lines. I won't take your time up now. We can save this country billions of dollars and bring prosperity to this country and to the rural areas you guys can't believe. And it will not hurt the American consumer.

We should have $5 corn, $12.40 beans, $7 wheat. And it wouldn't change the price of a loaf of bread or a box of corn flakes but a penny or two. We've got the overwhelming support of the American people. I know that because I have been traveling all over this country.

We are the new group that you should listen to.

Mr. JONES of Tennessee. Would you identify the group? Do you have a name?

Mr. EICKHOFF. Yes, sir, I sure will. I am proud of it. I am the State chairman of the Farmers, Ranchers, and Growers of Indiana. I am affiliated with the National Save the Family Farm Coalition that I helped put together out at Des Moines, IA. One hundred sev-

enty-one groups from 34 States were represented. We are growing like wildfire because we have solutions to tough questions.

We would love to work with you. If we all work together, we can solve this crisis and save this country billions of dollars. It can be done, sir.

Mr. JONES of Tennessee. Let me say I regret that we did not have you or your group as a witness today.

We did our best to cover the waterfront.

Mr. EICKHOFF. I know you did.

Mr. JONES of Tennessee. We need help ourselves.

Mr. EICKHOFF. You guys got a heck of a job. I don't envy it.

If we all work together—do you know how many farm deaths or suicides that we know of in this country? Over 400, and we think it's just the tip of the iceberg. The farm crisis—family farmers divorcing. It used to be the most stable, the farm family, in the whole country. And now it's pathetic. I know in my own case the wife and I are having all kinds of troubles because, where's the money coming from? Are you sure we can stay in farming? We can if we get a price that we can live with.

I will be glad to go into details. In fact, I have with some of your staff. I have talked to them. In fact, I have talked so much, I can't really talk anymore. And for me, that's rough.

Mr. JONES of Tennessee. We appreciate you being here.

Mr. EICKHOFF. Thanks a lot.

Mr. JONES of Tennessee. We will be glad to hear from you further.

Mr. EICKHOFF. I appreciate you listening to a grassroots farmer. Thank you, gentlemen.

Mr. JONES of Tennessee. Thank you very much.

The subcommittee stands adjourned until the call of the Chair.

[Whereupon, at 4:25 p.m., the subcommittee was adjourned, subject to the call of the Chair.]

[Material submitted for inclusion in the record follows:]

STATEMENT OF

THE AMERICAN BANKERS ASSOCIATION

I am Mike E. Fitch, Vice President for Agribusiness Affairs with Wells Fargo Bank of San Francisco, California, and current Chairman of ABA's Agricultural Bankers Division. Accompanying me today is Bruce Meriwether, President of the First National Bank, Dubuque, Iowa, and President of the Iowa Bankers Association.

Mr. Chairman, I represent the second largest commercial bank lender to agriculture in the nation. For the past 3-4 years, West Coast farm borrowers have been facing the same cost price squeeze that is affecting the Midwest and other heavily agriculture-dependent areas. At Wells Fargo, the agriculture portfolio has traditionally out-performed other loans, However, for the last two years agricultural loans have not performed nearly as well as the rest of Wells Fargo's portfolio because the farmers are not doing well. According to the Federal Reserve Bank of Chicago, California banks charged off more than twice as high a percentage of their agricultural loans outstanding in 1984 than banks in any other state.

Mr. Chairman, we appreciate the opportunity to address the problems of commercial banks involved in agriculture. The performance of the farm economy impacts more banks than many people realize. Of some 14,000 commercial banks, we estimate that more than 6,000 banks are substantially involved in agricultural lending (more than 10% of their portfolios). In addition, commercial banks hold $47 billion in agricultural debt. The agricultural economy contributes over one-fifth of the U.S. GNP considering both the direct and indirect impact of the industry. Agriculture has been a significant creator of new real wealth year after year and it is a major contributor to our national balance of trade.

Concern about the deteriorating agricultural economy and its impact on banks, their borrowers and their communities led the American Bankers Association and the Independent Bankers Association of America to establish a Joint Task Force on Agricultural Credit. The 13 member Task Force includes representatives from a broad cross-section of the agricultural banking industry. Mr. Meriwether and I both serve on it.

The Task Force has recommended a plan of action involving three main elements: (1) bank capital, (2) agricultural borrowers' financial conditions, and (3) farm real estate values.

The Task Force was formed because American agriculture is undergoing massive change that threatens both banks and their farm borrowers if they are not given time to adjust. Let me briefly discuss the problems of agriculture and the banks that lend to farmers.

Mr. Chairman, before I discuss the condition of commercial banks involved in agriculture and our farm borrowers, I want to express our Association's appreciation for the interest and involvement of members of this committee in the agricultural banking situation. The introduction of H.R. 3868 and H.R. 4267 with the banking and borrower components emphasized the importance of addressing the concerns expressed by commercial bankers about the agriculture financial situation. The response by the banking regulators that I will discuss later has lessened the need for aspects of these bills, but it has not lessened our recognition of the importance of these legislative initiatives. We appreciate them, and we hope to continue working with you, Mr. Chairman, and the members of this subcommittee and the full committee as we all continue to address the serious problems in the financing of agriculture.

Condition of Agriculture and Lenders to Agriculture

The agricultural sector of our economy is undergoing a period of massive strain and adjustment. Farm business failures and farm lender closings during 1985 occurred at a rate not seen since the Great Depression.

The current conditions in the agricultural sector are a by-product of the booming decade of the 1970s. During the 1970s, domestic and foreign farm sales grew sharply, increasing farm revenues at an annual rate of 10.1 percent. Much of this growth was fueled by exports which increased from just $7.0 billion in 1970 to $41.0 billion in 1980--an annual rate of almost 20%. By 1980, exports made up 30% of total farm sales compared to less than 15% in 1970. Thus, the growth in income that occurred through much of the decade was highly dependent on the farmers' ability to preserve or increase their share of exports.

There was a widespread belief--by government and private analysts--that foreign demand for our agricultural products would continue to grow at a much higher rate than we would be able to supply. This perception arose from the belief that low income nations would find it difficult to provide their population with food. Thus, U.S. farmers would have an unlimited market for their products.

However, the increased demand and slowly adjusting supply that made the decade a good one were short-term aberrations from the long-term trend. The trend for most of the 20th Century has been declining real prices for food products. In the current cycle, the trend has been restored. Prices dropped as supply far outstripped demand worldwide.

The result of this sudden and massive change in world

markets was an equally sudden drop in farm income and increase in agricultural credit problems.

The farm sector's economic condition has continuously deteriorated since 1981. Farm income measured in real terms has declined by over one-fourth, and the real value of farm assets has declined by nearly one-half. The net result has been an increase in real equity losses of approximately $211 billion over a four year period. Most of the losses in real equity are due to large declines in real estate values which fell from $780.2 billion in 1981 to $588.4 billion in 1985, a decline of 24.5 percent.

Farm debt is concentrated among less than 20 percent of the 2.2 million farmers in the U.S. Approximately 17 percent of all farmers are highly leveraged, with debt to asset ratios of over 40 percent. However, these farmers with debt to asset ratios in excess of 40 percent owe approximately 46 percent of the total farm debt. Given this high concentration of the farm debt and the unprecedented (post WWII) four year decline in land prices, we can expect unprecedented rates of farm failures in the absence of corrective policy actions to assist banks as they work with their farm borrowers.

As the agricultural economy goes through a period of adjustment, so are lenders to this key area of our economy.

Commercial banks hold a large portion of the agricultural debt. The Federal Reserve Board estimated that during 1985 commercial banks held $47 billion or 22 percent of the total. A large portion of this farm debt (80 percent) held by commercial banks is in the form of non-real estate debt for farm production loans. The commercial banking sector is the largest lender for farm production purposes.

These banks that lend to agriculture are under great stress. The 120 commercial bank failures in 1985 almost equaled the combined failures in 1983 and 1984, and the number of failures during the year was the most since the Great Depression. A recent report issued by the Federal Deposit Insurance Corporation concluded: "Agricultural bank failures took a sudden upturn during the second half of 1985. During the past 14 months farm banks accounted for just over 50 percent of all bank failures. Nonagricultural banks have been failing at about the same pace in 1985 as 1984, meaning that agricultural bank failures almost totally account for 1985's increased failure rate."

Table 1
Bank Failures by Type of Bank

| | 1982 | 1983 | 1984 | 1985 |
|---|---|---|---|---|
| Agricultural banks | 7 | 7 | 25 | 62 |
| Other banks | 27 | 38 | 53 | 56 |
| Savings banks | 8 | 3 | 1 | 2 |
| Total | 42 | 48 | 79 | 120 |

Delinquency rates on farm loans at all commercial banks have been increasing. Nationwide, in September 1985, 9.2 percent of farm production loans outstanding were classified as either non-performing loans (these are loans past due over 90 days and still accruing interest, past due in nonaccrual status, and renegotiated debt) or past due 30 - 89 days. This was a 42 percent increase from the level experienced during the same period in 1984 and up 119 percent from the same period in 1983. Much of the upward trend in delinquency rates consisted of increases in nonaccrual loans (loans on which neither principal nor interest are being paid) which grew from 3.8 percent in September 1984 to 5.6 percent in September 1985, an increase of 47 percent in a single year.

Farm production loans charged off by insured commercial banks totaled $900 million in 1984, up from $436 million the year before. In the first three quarters of 1985, charge-offs came to $755 million. This is 63 percent above the charge-offs experienced during the first three quarters of 1984. If this trend continues, the FDIC estimates that the total of such charge-offs at commercial banks may come close to $1.5 billion for the full year of 1985. It is likely that a large portion of these losses will be concentrated on banks in the western corn-belt and the great plains states where loan quality has deteriorated more rapidly.

The adjustment process in agriculture has weakened some farmers and contributed to the deterioration of agricultural banks. This certainly does not mean that large loan charge-offs at agricultural banks threaten the safety and soundness of the financial system. But the spiral of farm economic problems and bank failures are harming not farmers and bankers alone, but also the communities they serve. These farmers and banks and their surrounding communities can be expected to survive, but only if they are given more time to adjust to the massive changes now going on in agriculture.

Mr. Chairman, the ABA-IBAA Joint Task Force developed recommendations addressing three major aspects of the agricultural credit problem facing commercial banks and their borrowers: (a) bank capital, (b) borrowers' financial

conditions, and (c) farm real estate values. These are the key areas that we believe must be addressed. However, we do not believe that we have identified the only means to address the problems in these areas. We are making proposals, but we are also willing to listen to any others. We want to work with this committee, the bank regulators, and any others to develop solutions to a very serious problem that is worsening.

I. Stabilization of Bank Capital

Banks are required by the bank regulators to maintain specific levels of capital. If a bank's capital falls below the minimum required by the regulatory agencies, the bank is subject to enforcement actions which may lead to closure.

Stabilizing bank capital is important because it is difficult for bankers to work with their farm borrowers to provide new credit for planting, restructure existing debt, or work out other solutions if the banks are in imminent danger of facing regulatory action because their level of primary capital drops below 5.5 percent. As stated earlier, the sudden change in the agricultural economy is resulting in great increases in agricultural loan charge-offs. Banks need time to absorb these losses so they can continue to work with their borrowers and remain of service to their communities. Sticking to a rigid rule on capital will not serve the public well in agricultural communities that need banking services.

Bank capital requirements are an important regulatory tool. In particular, they provide a buffer that helps protect deposit insurance fund reserves. In deciding the proper level of required capital for any bank, regulators must delicately balance these tradeoffs. Sometimes the level of capital to be striven for over the long run should be examined and adjusted due to circumstances. For agricultural banks, we believe now is such a time.

To keep agricultural banks open and to maintain their capacity to extend credit to borrowers, we recommend that special measures be implemented to stabilize the capital structure of agricultural banks. Agricultural banks traditionally have been well capitalized. However, the persistent downturn in the farm economy since 1981 has been severely pressuring the capital structure of hundreds of agricultural banks. Given time, the agriculture economy will recover, providing a basis for greater earnings and replenishment of the capital structure of agricultural banks. In the meantime, we need measures to prevent prudently managed banks' capital from being precipitously eroded with the resulting regulatory actions and, possibly, large numbers of closed banks.

Bank Regulators' Policy Announcements on Capital Forbearance

Mr. Chairman, we are pleased that in recent public announcements the banking regulators delineated a specific policy of direct capital forbearance. The Office of the Comptroller of the Currency, the Federal Deposit Insurance Corporation and the Federal Reserve Board all adopted a new policy permitting prudently managed banks experiencing difficulties because of the agriculture or energy economy to drop below the minimum capital requirement provided the bank has the capacity to restore capital within five years.

Mr. Chairman, while this announcement was only made on March 28, the reaction from bankers who are becoming aware of it is positive. We shall closely monitor its implementation to determine its effectiveness, but we are pleased by this policy change by the regulators. This recognition of the banks' capital situation in agricultural areas will help stabilize agricultural banks in the regions under the greatest impact from the deteriorating farm economy.

H.R. 4267 includes one provision directly relevant to this issue of bank capital levels. In Title III, H.R. 4267 would authorize the amortization of agricultural loan losses over a period of ten years. We appreciate the inclusion of this provision because amortization of loan losses was one of the options for stabilizing bank capital proposed by our Joint Task Force. However, the announcement by the bank regulators of their capital forbearance policy appears to achieve the same result--a reduction in regulatory pressure on bank capital levels and consequent negative impacts on borrowers. Therefore, we do not believe that legislation authorizing the amortization of loan losses is needed at this time. We do believe that the introduction of such legislation served as an important impetus for the regulatory action, and we appreciate the efforts of members of this committee to respond to the difficulties facing commercial banks that lend to agriculture.

Mr. Chairman, while outside the jurisdiction of this Subcommittee, there is a tax issue which should be mentioned because it also affects banks' ability to maintain capital levels adequate for the regulators. Under the current Internal Revenue Code, banks that experience a net operating loss may deduct that loss against income from their prior ten years of operation, and, if necessary, from their next five years. The House passed tax bill (H.R. 3838) would only permit banks to carry losses back three years, with fifteen years to carry them forward. For banks that experienced losses and had no income in earlier years, this change would be beneficial. Many banks, however, particularly in the Farm Belt, had income in earlier years but currently are experiencing heavy losses. The provision

in present law allowing banks to look back ten years was designed to help cushion banks in this position. If this change were to become law, without even a phase-in period, agricultural banks with net operating losses would find their levels of capital even more difficult to maintain.

II. Stabilization of Agricultural Borrowers

The massive reversal of agricultural fundamentals--a return to a less inflationary environment, structural changes in financial markets, and U.S. integration into a world market for food and fiber--require extraordinary cooperation on the part of lenders, borrowers, and others. The banking industry is deeply concerned about the economic problems facing the American farmer. Bankers work closely with farm families in the management of their financial affairs and are quite aware of the financial difficulties many farmers are facing today. Many agriculture-related businesses, which provide products and services to farm families in rural America, are also suffering as a result of the financial problems of farmers. We believe the best approach for assisting these customers is for banks to work in partnership with regulators, customers and others to arrive at acceptable solutions. Forbearance and cooperation, until the farm economy improves, are the key to overcoming this economic crisis.

Banks already have engaged in loan renegotiation, interest-only payment plans, extension of loan maturities, and even significant rate reductions to assist struggling small business and farm borrowers through the current difficult period. We shall continue to do so. Federal assistance in the form of Farmers Home Administration guarantees or interest rate buydown programs enable more of us to help more borrowers. We believe this to be a very positive approach to helping those farmers who still have viable operations but who are caught up in the current financial crisis.

In addition to their announcement on capital forbearance, the bank regulators also announced two other policy changes that remove regulatory disincentives to loan restructuring. Until this announcement, banks were discouraged from restructuring loans by the regulations. These changes should aid banks as they try to work with their borrowers.

The first policy change involves acceptance of Financial Accounting Standard No. 15, a Generally Accepted Accounting Principle (GAAP). Previously, particularly under FDIC rules, if a bank restructured a loan, any reduction in expected bank income below that contained in the original note had to be considered a loss. Under the new policy, as long as a bank expects to receive an amount equal to the

original principal and interest accrued (up to the date the loan is modified) over the life of the restructured loan, the bank does not have to recognize any loss. This policy change helps banks work with their borrowers by restructuring loans while also protecting the banks' capital levels.

The second policy change involves the reporting of restructured loans. Previously even if a bank restructured a loan and recognized a loss on the reduction from the original note, and even though the borrower made payments under the restructured terms, a bank had to report the loan to the regulators as nonperforming because it did not meet the provisions of the original note. Bank examiners classified these restructured loans as nonperforming. The regulators have created a new category for restructured loans that means such loans will no longer be classified norperforming but rather be put in a new category, "Restructured and in Compliance with Modified Terms".

These two policy changes together remove a major regulatory disincentive to debt restructuring.

Mr. Chairman, we recognize the budget constraints within which the Congress is now working. Therefore, since the Farmers Home Administration loan guarantee programs are the least costly means of stabilizing, restructuring, and extending agricultural credit, we recommend a continued focus on the guarantee program.

Bankers are working with the FmHA guarantee program. According to the Department of Agriculture, on March 31 of this year there were almost three times as many FmHA Guaranteed Operating Loans (3,754) as there were at this time a year ago (1,236). There was a 240 percent increase in the total of guaranteed funds obligated ($438.6 million compared to $180.5 million in 1985) by March 31, 1986.

Use of the guarantee program does vary state-by-state and county-by-county due to variations in the degree of commercial bank involvement in agriculture, knowledge of and support for the program on the part of both lenders and FmHA administrators, and sheer volume of work in local FmHA offices.

We recognize the demands being made on FmHA staff, but prompt processing of applications is absolutely essential to the working of the guarantee program. When lenders do not receive prompt action on applications, they are hesitant to spend the time filling out new ones.

We are also supportive of the interest rate buydown program included in the 1985 Farm Bill. For some farmers, this type of direct assistance is the only thing that can

allow them to survive. Unfortunately, the regulations only reached many FmHA county offices in mid-March. Our experience with programs of debt-adjustment clearly demonstrates that new programs, announced well into the planting season, are difficult for commercial banks to use because neither the FmHA administrators, the bankers, nor the farmers are familiar with the requirements. In addition, all new programs have adjustments that need to be made once the regulations are tried out in real world situations.

For example, while the interest rate buydown program has only been available for a few weeks, we have heard of many questions concerning the requirement that eligible farmers divest themselves of "any assets which do not contribute to essential family living expenses or to the maintenance of a sound farming operation." Who defines these assets? Who has the authority to disapprove an application on this basis? Both the lender and the County Supervisor are mentioned. This requirement is one example of items that need clarification.

Both H.R. 4267 and a proposed substitute for H.R. 3868 include debt restructuring and interest rate buydown provisions. We appreciate and share the concern of Members of this Committee about our farm borrowers demonstrated by these proposals. If funds are available to broaden the interest rate buydown program, we support this approach and look forward to continuing to work with the Members of this Committee to develop the most effective program that benefits our farm borrowers and guarantees continued availability of credit to agriculture.

III. Stabilization of Farm Real Estate Values

Mr. Chairman, as mentioned earlier, the value of farm sector assets has retreated since peaking in the early 1980s. The most pronounced decline has been in land values, which nationwide are off 19% since 1981. The extent of the decline varies widely among states, with the sharpest declines occurring in the western Corn Belt and the southern Plains states. Land value declines since the 1981 peak range from nearly 20% in Michigan to more than 45% in Iowa.

Our Association is interested in exploring possible solutions to the major problem of declining land values. An immediate action that would help reduce the downward pressure on farm land values would be changes in the requirements that banks divest themselves of agricultural real estate within a short period of time (five years for national banks, with an additional five years with Comptroller approval).

Dumping that land on a declining agricultural real

estate market merely further deflates the asset values to which all of the lending in rural communities is tied. As a short-term measure, permitting banks to hold that agricultural land somewhat longer would definitely help stabilize farm real estate values.

The Joint Task Force recommended that the current limit of five years (with an additional five years if the Comptroller approves) be extended to ten years with an additional five years discretion for the Comptroller for national banks. States should be urged to make similar changes for state banks to prevent further dramatic declines in the value of farm land.

Due to the current agricultural situation, a farmer's long-term financing options are extremely limited. Agricultural banks are exploring the development of other sources of long-term credit, beyond traditional sources, which could provide competitive and stable funds for American farmers.

The acquisition of funds is an ongoing serious concern of the country's agricultural banks. During periods when interest rates are high, the small and medium size banks have difficulty in obtaining long-term loanable funds. On a long-term basis, it would be useful to create a true secondary mortgage market for real estate loans so that banks will have the opportunity to tap capital markets.

The ABA proposes the development of a secondary market for farm real estate. Providing banks with a secondary market for agricultural real estate would enable these banks to provide real estate financing at reasonable rates to the farm sector.

According to the Federal Reserve Board's 1985 estimates, the Farm Credit System holds 44.04% of the farm real estate debt, insurance companies hold 11.2%, Farmers Home Administration 8.87% with 26.79% held by individuals and others. Banks only hold 9.01% of the farm real estate debt. Banks cannot lend for long periods of time on farm real estate unless they have either long-term funds or a secondary market.

The development of a secondary market, perhaps with FmHA guarantees, would permit banks to make farm real estate loans, to sell these notes on the secondary market to maintain liquidity, while retaining the servicing and local involvement with their farm borrowers.

This secondary market would enable banks to continue financing farm real estate in periods of reduced bank liquidity because the loans could be sold to investors in this market. The development of this stable competition

with the Farm Credit System would benefit both farm borrowers and their communities. Increasing competition, spreading the risk of financing farm real estate, and keeping banks as viable lenders all will help stabilize farm real estate values in rural communities.

Through the creation of such institutions as the Government National Mortgage Association (GNMA) and the Federal National Mortgage Association (FNMA), Congress has shown its support for encouraging participation in the secondary markets. These institutions are actively facilitating the needs of the mortgage industry by purchasing mortgages from the originator and reselling them to investors.

Because of these organizations the housing industry has enjoyed the benefit of a highly competitive and efficient credit delivery system. We would urge the government to play an active role in developing a secondary market for farm real estate.

Conclusion

It is particularly important that cooperative efforts are taken now to help with the current credit and cashflow problems facing farmers and commercial banks in many of our major agricultural regions. We certainly compliment this committee for turning its attention to the credit issue at this time. That is also why we are pleased by the announcements by the regulators that eliminate the regulatory disincentives for debt restructuring and that institute capital forbearance.

Our objective is to provide those banks and farmers who have the potential of survival with the opportunity to return to profitability. However, given the dramatic rate of adjustment in the agricultural economy occurring at this time, without some programs such as described above, many banks and borrowers with previously successful operations face insolvency.

Mr. Chairman, while we need time now we are also working as an Association to look to the future. The ABA has commissioned a comprehensive research report to assess: (1) the major trends in agricultural banking, (2) the future of the agricultural sector, (3) the agricultural credit delivery system, (4) regulatory and legislative actions consistent with these findings, and (5) a strategic planning guide to assist individual banks in their business plans and agricultural lending decisions.

Mr. Chairman, we will continue to explore the above mentioned issues with the Congress and the regulators.



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STATEMENT OF JOHN C. DEAN, CHAIRMAN, AGRICULTURE-RURAL COMMITTEE, INDEPENDENT BANKERS ASSOCIATION OF AMERICA

Mr. Chairman and members of the Subcommittee, I am John Dean, Chairman of the Agriculture-Rural Committee of the Independent Bankers Association of America. I also serve as President of the Glenwood State Bank in Glenwood, Iowa.

We appreciate your interest in the serious problems involving agricultural debt and the financing of farm producers this year, and we are pleased to participate in these hearings.

At the end of 1985, commercial banks held about $47 billion of the outstanding farm debt, composed of $36 billion of production debt and $11 billion of real estate debt. This represents a 10 percent reduction of production debt and a 12 percent increase in real estate debt, compared with the end of 1984.

Net charge-offs of farm production debt by banks in 1985 totalled $1.3 billion, or 3.7 percent of the total of such debt. This is an almost 45 percent increase in the $900 million charged off in 1984.

Estimated delinquent farm production loans at commercial banks at the end of 1985 totalled $3.7 billion, of which $2.7 billion was categorized as nonperforming. The nonperforming loans include those past due 90 days or more and still accruing interest, non-accruing loans, and renegotiated loans.

Banks generally have ample funds for lending to agriculture, and most of the bank's farm customers now have their operating credit in place for 1986. However, there are many cases in which farmers are having difficulty qualifying for 1986 operating funds. The options available to lenders for working with such cases have become quite limited. The severe constraints on Federal expenditures in this area have also rendered this means for relieving the financial pressures less effective.

We have been working with the bank regulators and Congress to provide greater operational flexibility to banks in handling problem farm loans. We have emphasized the need for greater flexibility with respect to bank capital requirements as agricultural banks work with problem farm loans and loan charge-offs.

The two measures that are now being implemented by the bank regulators--capital forbearance and FASB-15--are quite similar to concepts included in H.R. 3868 and H.R. 4267 which are pending before this Committee. I would like to briefly review those measures that are being put into place by the bank regulators.

Capital forbearance as implemented by the FDIC, Comptroller of the Currency, and Federal Reserve will enable banks substantially involved in agricultural or oil and gas lending to participate in a program under which they may draw

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down their capital as low as 4 percent of assets (in special cases, 3 percent), where the pressure on bank capital is due to problem loans in agriculture and energy. The capital draw-down can be linked to a new Comptroller of the Currency policy on bank lending limits which is designed to preserve the size of an individual loan that the bank is permitted to make at or near the size permitted prior to the reduction in the bank's capital level.

FASB-15, which refers to a financial accounting standard that is consistent with generally accepted accounting principles, allows a bank to renegotiate a note case with a borrower and forgive repayment of a portion of the principal owed on the note while taking as a loss deductible against the bank's capital only the amount by which the forgiven debt exceeds the interest that will accrue on the remaining note until maturity. Under FASB-15, the bank examiners will not classify the remaining note as a problem loan, if the loan is performing under the modified terms.

I have attached a copy of each of three weekly reports to our membership that IBAA prepared on these measures, as they were developed by the bank regulators.

We believe that those regulatory measures provide useful, additional flexibility in dealing with problem loan cases. Each loan case is different, and whether one or another of these options is employed will depend on the circumstances of

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each specific case. This additional regulatory flexibility can benefit farm borrowers in several ways. These measures will give some renewed confidence to agricultural bankers to encourage extension of credit to farm borrowers. Maintaining the bank's prior lending limit while reducing capital levels can enable a bank to continue supplying the full credit needs of specific farm borrowers whose needs might otherwise exceed the bank's individual loan lending limit. The FASB-15 procedure involves the forgiveness of a portion of the farmer's debt.

These measures that are being developed by the regulators have the potential of accomplishing the basic objectives that a formal multi-year loan loss amortization procedure would be expected to perform, and we believe that proper implementation of those measures should now be emphasized.

The FmHA loan guarantee program provides another important means for handling stressed farm loans. That program is being used extensively in many heavily agricultural states. For instance, as of April 2, obligated guaranteed operating loans were $65 million in Iowa, $60 million in Nebraska, $50 million in Minnesota, $33 million in Oklahoma, $26 million in Texas, and $24 million in Kansas.

The interest rate buy-down program under the 1985 farm bill has been available only a few weeks, and apparently interest in this program is growing as the initial

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difficulties are worked through. Iowa recently added an additional interest reduction to this program, as it operates in the State. The interest rate buy-down is fully authorized in the 1985 Act, and because it is tied into the Agricultural Credit Insurance Fund it can be expanded merely by providing additional funding authority under the ACIF revolving fund. We support an expansion of funding as the demand for this program warrants, to the extent that funding can be provided without depriving other priority programs. We recognize that you face hard choices in the allocation of funds among deserving programs. We see no reason to rewrite the interest rate buy-down program at this time.

Direct FmHA lending obviously remains critical for farmers in many situations, and we support maintaining the funding for direct loans necessary to meet the needs of eligible farm borrowers.

One new avenue of farm lending that we are pursuing is the development of a broader secondary market for longer-term farm loans originated by commercial banks. If secondary marketing institutions can be developed for farm mortgages, commercial agricultural banks could originate a larger volume of farm real estate mortgages for resale. This could expand long-term credit sources for farmers. We would like to work with you in getting such a secondary market firmly established.

The ability of farmers to cash flow their debt load, both existing and new debt, remains the bottom line consideration in the financing of production agriculture this year. As indicated, certain programs and policies are now in place, that provide greater flexibility in enabling commercial lenders to accommodate qualifying farmers' credit needs. I am confident that agricultural banks and their borrowers will generally make the best possible use of those measures during this lending and production season.

This concludes my statement, and I would be pleased to respond to any questions.

(Attachments follow:)

SPECIAL SUPPLEMENT TO THE WASHINGTON WEEKLY REPORT March 31, 1986

## New Options for Loan Loss Amortization

The bank regulators are now adopting two different regulatory policies that will be available to banks as options with which banks might preserve their capital levels while recognizing losses on agricultural loans. The two options, both of which involve variations of loan loss amortization, are: (1) capital forbearance and (2) FASB-15. The latter option (FASB-15) is available now; more details on capital forbearance will become available very shortly.

The way in which FASB-15 can be used is outlined below. Bankers may want to keep their options open in handling specific note cases until the capital forbearance option can also be considered. FASB-15 and capital forbearance will differ in terms of tax consequences and the requirement of debt forgiveness. The capital forbearance option may be more generally applicable, since it will not require the unusual step of debt forgiveness.

Although the emphasis with regard to capital forbearance and FASB-15 is upon troubled agricultural debt, these procedures will probably be generally available for handling other troubled debts (particularly energy loans).

### FASB-15

FASB-15 refers to the Statement of Financial Accounting Standards Number 15 for Accounting by Debtors and Creditors for Troubled Debt Restructurings. The use of FASB-15 conforms to generally accepted accounting principles. Chairman Bill Seidman of the FDIC has instructed all FDIC examiners to accept FASB-15 procedures in classifying any bank loans, as long as the examiners are comfortable with the ultimate collectibility of such restructured loans. Comptroller Robert Clarke and the Federal Reserve have also emphasized that FASB-15 is available for use.

The use of FASB-15 allows a bank in effect to amortize a loan loss over the life of the new note, in cases where the lender renegotiates debt and forgives part of the principal so that the borrower can then cash flow the remaining debt as restructured in the new note. FASB-15 thus offers a potential alternative to foreclosure, but it requires that the lender take the unusual step of forgiving a portion of the principal that is owed.

As an illustration, assume a note case involving $400,000 of debt on which, for whatever circumstances, it is decided that the borrower can cash flow a maximum of $200,000 if that amount is amortized over 7 years with an increase in the interest rate from 12 to 13 percent. For purposes of determining the amount of loss to be deducted from the bank's capital, FASB-15 allows the lender, when the new $200,000 note is issued, to add to the principal the interest income that will accrue on that $200,000 over 7 years (in this example, $116,555 of interest). Thus, the first-year loss as a deduction against bank capital is $83,445 ($400,000 minus $316,555). In effect, the full $200,000 loss will be amortized over the 7 years, since income from the loan that will accrue over 7 years has been totally credited at the beginning of the new 7-year note.

For FASB-15 to serve its intended purpose, it would appear desirable to emphasize reduction in principal, and perhaps increase the interest rate, in order to minimize the amount of front-end loss that is offset againstthe bank's capital.

For tax purposes, it is generally believed that the entire $200,000 of write down of debt in the above example can be taken immediately by the bank as a tax deduction. The $200,000 is forgiven to the borrower, and therefore should be immediately deductible by the lender. The same $200,000 would constitute ordinary income to the borrower for tax purposes, subject to any special circumstances that apply.

Although the above debt restructuring example involved simply a modification of principal and interest, it is permissible to include a transfer of borrower assets and still use FASB-15. To do that, you subtract the value of the assets or equity interests that are transferred from the borrower to the lender, and then (unless that transfer is accepted as full settlement of the debt) you merely handle the modifications in the remaining debt according to FASB-15. For example, if the $400,000 in the above illustration was reduced to $300,000 by a transfer of assets, then the remaining $300,000 can be further modified (with reduction in principal and changes in the interest rate on a new note), complying with the FASB-15 procedures.

In a FASB-15 situation where the total interest income that will accrue on the new note after renegotiation exceeds the amount of principal forgiven, you would show no loss as an offset against bank capital at the beginning of the new note. In the above illustration, if the amount of principal forgiven remained $200,000 but interest income on the new note would total $205,000 (rather than $116,555), no loan loss would be recorded initially. The $200,000 would still be immediately deductible as a loss for tax purposes.

The FDIC, Comptroller of the Currency, and Federal Reserve are taking unified action, revising the bank call report to provide a separate reporting category for loans that are restructured and are in compliance with the modified terms of the new loan. Such restructured loans would no longer be categorized as nonperforming loans. The regulators made the joint decision approving this new call report category last Friday.

Capital Forbearance

As indicated, before electing to use FASB-15 for specific note cases, bankers will want to consider the forthcoming option of capital forbearance, on which more information will be available shortly. The capital forbearance option will allow a bank experiencing difficulties to operate below the minimum capital requirement (possibly as low as 3%) provided the bank has the capacity to restore capital within 5 years. Thus, capital forbearance may meet the need for preserving a bank's capital and lending capacity, while recognizing agricultural loan losses, without requiring the forgiveness of debt. And of course the full consideration of options must still include the possibility of foreclosure or other type of liquidation, which may be the only reasonable course of action.

## Bank Capital and Lending Limits Preservation Policies

In addition to the FASB-15 procedures, the other regulatory flexibility option now being provided is capital forbearance linked with adjustments in lending limit regulations. The "linkage" between the procedure allowing reduced capital levels and preserving banks' higher lending limits is complicated by the fact that jurisdiction is split between FDIC (with primary control over reduced capital) and OCC (with control over lending limits).

### Capital Forbearance

Chairman William Seidman is providing the details on FDIC's capital forbearance program in a letter of March 27 to all state-chartered banks that are not members of the Federal Reserve System. That program, which is effective immediately and extends through January 1, 1993, provides that the FDIC will not take administrative action to enforce normal capital standards against banks whose primary capital ratio declines to no less than 4 percent between now and December 31, 1987, provided the bank participates in the capital forbearance program under the following conditions:

- The bank must be an "agricultural" or "energy" (oil and gas) bank, whose agricultural and oil and gas loans (either separately or in combination) comprise at least 25 percent of the bank's total loans and leases.

- The weakened capital position of the bank must be largely the result of external problems in the agricultural and/or oil and gas sectors of the economy, and not due to "significant mismanagement" or related factors.

- The bank must submit to the FDIC a plan for restoring capital to the required minimums in incremental amounts by not later than January 1, 1993. This plan must address certain areas specified by FDIC, such as compensation to directors. The bank must agree to file an annual progress report with the FDIC regarding its capital plan and to keep the FDIC informed of material variances from the plan.

Banks seeking to participate in this program should provide written notification to the Regional Office of the FDIC, including evidence of the bank's eligibility and its plan. Participation in the program is granted unless, within 60 days of receipt of the application, the FDIC notifies the bank that its request has been denied or informs the bank that additional information is needed.

Capital forbearance could be extended to banks with primary capital ratios as low as 3 percent in special circumstances, if a bank's plan indicates that an increase to 4 percent will occur within a relatively short time (generally 12 months or less). However, approval of such a reduction in capital is discretionary with the FDIC, whose positive written approval would be required. In addition, the FDIC does not rule out extending the capital forbearance policy to a bank experiencing losses due to agricultural

and energy problems but not meeting the 25 percent test for an agriculture/energy bank; these situations would be handled by the FDIC Regional Office on a case-by-case basis.

Lending Limits

Comptroller Robert Clarke is developing the regulatory procedures designed to preserve the limit on the size of individual loans at or near the level of a bank's lending limit prior to the reduction in capital resulting from a bank's participation in the capital forbearance program. This protection of lending limits would apply directly to nationally-chartered banks only. However, perhaps two-thirds of the st. have "wild card" statutes under which the Comptroller's policies for preserving a bank's lending limits could be applied to state-chartered banks either automatically or by administrative action (that is, without requiring state legislative action).

In addition, the Comptroller's program of capital forbearance for nationally-chartered agricultural and energy banks (not yet issued as of March 27 but expected to be issued within a very few days) may provide for preserving the lending limits of higher-capitalized banks that reduce their capital under a capital forbearance program but still retain at least 5.5-6 percent capital. If so, that aspect of the program probably would not require the bank to submit a plan. As indicated, however, the Comptroller's capital forbearance program has not been finalized and issued.

To participate in a capital forbearance policy, a bank in each case will work with its primary regulator: nationally-chartered banks with the Office of the Comptroller, state-chartered non-member banks with the FDIC, and state-chartered banks that are members of the Federal Reserve with the Federal Reserve Banks. The Federal Reserve's capital forbearance program is also expected to be issued within a few days, and will be administered through the Federal Reserve Banks in the respective districts.

SPECIAL SUPPLEMENT TO THE WASHINGTON WEEKLY REPORT April 3, 1986

## Bank Regulators Finalizing Capital Flexibility Options for Agricultural and Energy Banks

The bank regulatory agencies have almost completed the transmittal of information on the "capital flexibility" policies that they are implementing for agricultural and energy banks. All state-chartered banks which are not members of the Federal Reserve System should have received FDIC's March 27 letter on its capital forbearance program. All nationally-chartered banks should have received the Comptroller of the Currency's March 28 letter on the Comptroller's capital forbearance and lending limits policies. The Federal Reserve's related policies for state-chartered member banks was provided to the various Federal Reserve Banks rather than directly to those commercial banks.

Among the various measures being implemented (capital forbearance, lending limits protection, and FASB-15), only the Comptroller's lending limits policy requires a formal, published regulation. That regulation will be published in the Federal Register within a very few days, and is not expected to deviate materially from the explanation contained in the Comptroller's March 28 bank letter. The OCC lending limits policy will be immediately effective for nationally-chartered banks upon its publication, although a comment period will be provided with the possibility of changes based upon the public comments that are received.

Although the OCC's adjustment in legal lending limits may be essential in order to make the capital forbearance policy useful for banks, the lending limit adjustments will not be available to state-chartered banks except in states that opt into the lending limits policy based upon either a state "wild card" statute or (in the absence of "wild card" authority) special legislative action. Some agricultural states (Iowa and Nebraska, for example) do not have existing "wild card" authority, and in such a state it is important to consider legislation during the pending legislative session enabling the state to opt into the OCC program.

The following comments on the capital forbearance/lending limits policies may be useful for a bank's preliminary interpretation of those policies:

- Once a bank meets the eligibility requirements for capital forbearance including that the bank must hold agricultural and oil and gas loans comprising at least 25 percent of the bank's total loans and leases, then charge-offs on any type of loan (not only agricultural or oil and gas loans) can be included in the capital forbearance program whereby the bank would draw down its capital as low as 4 percent (3 percent in special circumstances).

- However, for the OCC's policy to offset the impact of the reduction in capital on the bank's individual loan lending limit, only the Special Category Loans (defined as agricultural and oil and gas loans) would be covered. The OCC is holding open the possibility of adding other types of loans to this Special Category, but has not done so initially.

• The OCC capital forbearance policy extends not only to banks whose capital ratios would decline below 5.5 percent, but also to higher-capitalized banks that reduce their capital under a capital forbearance policy and yet retain a ratio over 5.5 percent after the reduction in capital. Such banks need not apply for capital forbearance and submit a plan under the 60-day approval procedure. A potential advantage of participating for such a bank is that the lending limits offset would apply, and therefore the bank might preserve its legal lending limit at or near the level prevailing before the reduction in the bank's capital.

• The OCC's policy to offset the reduction in a bank's legal lending limit that would otherwise result from participation in the capital forbearance program, is designed to maintain a bank's general lending limit at 15 percent of the bank's unimpaired capital and surplus which existed prior to the reduction in bank capital--except that the "offset" lending limit could not exceed 20 percent of the bank's capital after the reduction. Therefore, a bank could reduce its capital by as much as 25 percent without lowering its general legal lending limit below 15 percent. For example, a $1 million capitalized bank with a $150,000 general lending limit could reduce its capital to $750,000 (25 percent) without impairing its general lending limit ($750,000 x 20% = $150,000). Any further reduction in capital would reduce the general lending limit somewhat below 15 percent based upon the prior capital level, because of the 20 percent ceiling on the offset.

This lending limit offset would also protect the special lending limits in existing law which allow the lending of an additional 10 percent (i.e., 25 percent of capital) to the same borrower if the loan is fully secured by readily marketable collateral, and the lending of even higher percentages of capital to the same borrower in specified exceptions (FmHA guaranteed loans, certain types of agricultural loans, etc.). However, those lending limits may not be completely preserved. For example, a $1 million capitalized bank with a $150,000 general lending limit that reduced its capital by 25 percent, but that had a $250,000 loan (the additional 10 percent) to a borrower where the loan was fully secured by readily marketable collateral, might have its lending limit reduced by $25,000 on this loan case ($750,000 x 20% = $150,000; $750,000 x 10% = $75,000; $150,000 + $75,000 = $225,000).

As indicated, the OCC's lending limit "offset" policy will be published within a few days, and is subject to change based upon the public comments that are received by the agency. But that regulation will be effective immediately upon publication, and therefore the regulators' package of capital flexibility options (capital forbearance, lending limits protection, and FASB 15) are basically in place and available for application to specific banks and note cases.

THE FARM CREDIT COUNCIL
1800 MASSACHUSETTS AVE., NW / WASHINGTON, DC 20036 / 202 466-4180

Statement by

Douglas D. Sims
Member of the Legislative Committee
The Farm Credit Council

On Agricultural Credit Conditions
before the

Subcommittee on Conservation, Credit and Rural Development
Committee on Agriculture

April 9, 1986

Mr. Chairman and Members of the Subcommittee:

My name is Doug Sims and I am the Chief Operating Officer of the Farm Credit Banks of St. Louis. I am testifying today as a member of the Legislative Committee of The Farm Credit Council, the nationwide trade association of borrower-owned farm lenders. The Council is made up of the 37 Farm Credit Banks and more than 90 percent of the Federal Land Bank and Production Credit Associations which make up the Farm Credit System and its nearly one million farmer/owners.

We appreciate the opportunity to appear before this Subcommittee to share our perspective on the serious financial issues confronting many U.S. farmers, cooperatives and their major provider of credit, the institutions of the Farm Credit System.

We first want to thank you Mr. Chairman, Mr. Coleman and the Members of this Subcommittee, for your diligence and your leadership in guiding the Farm Credit Amendments Act through the House this past fall. To you, we owe a special debt of gratitude for moving enormous obstacles and ultimately helping to obtain legislation which establishes the Farm Credit Administration as an arms-length regulator, provides an improved mechanism to administer System self-help and puts in place a backup mechanism for Federal financial assistance if the System's best efforts to manage its financial problems are unsuccessful.

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Last Fall, the Farm Credit System provided detailed information to the Congress on the depth of its funding and financial problems. The somber projections we made at that time proved to be very accurate.

System Year-End Report

On February 14, 1986, the Farm Credit System announced its 1985 financial results, which included Systemwide operating losses of $2.7 billion. During 1985, the System charged off $1.1 billion in loans and made provision for future losses of $3.1 billion.

Our 1985 financial results mirrored another devastating economic year for many of our borrower/owners. Non-accrual loans totaled $5.3 billion, up $3.5 billion from a year earlier. On a Systemwide basis, acquired property increased from $504 million to $928 million during the year. Another $4 billion in loans which require more than normal servicing were identified and are now considered "high risk." These are the loans which, absent some material improvement in farm income, will be in serious jeopardy within the next two years.

Last year, Congress told the Farm Credit System to use its earned surplus to absorb losses. We in fact did that and in so doing, depleted 70 years of earned surplus by almost 45 percent from $6.2 billion to $3.4 billion.

These numbers and the complete financial report of the Farm Credit System for 1985 are contained in the System's Annual Report to Investors which has just been released. Copies will be provided to the members of the Subcommittee later this week.

As you review the Report to Investors, I urge your special attention to the unqualified audit opinion of Price Waterhouse, which is included in the report. Certainly, it is our fervent hope that these results will not be repeated in 1986.

The legislation which Congress enacted last year was very important to the farmers and ranchers who own as well as borrow from the Farm Credit System. The impact of the legislation was immediate and important in two respects. First, last fall the System came dangerously close to being shut out of the financial markets. Because of the legislation, the System's ability to sell its securities in the financial markets in the desired amounts and maturities was restored. Second, the cost of funds to the System skyrocketed late last year, threatening to add millions to the cost of credit for Farm Credit borrowers. Today the cost of money to the System has stabilized some 90 basis point below last year's peak spread against Treasury securities resulting in a savings to farmer-borrowers of more than $400 million on an annualized basis. The statute shored up a number of stockholder rights. We sense a renewed confidence in the System from investors, employees as well as borrowers.

Through the legislation, a funding crisis was averted. What has not changed, however, is the fact that the System remains essentially a single industry lender--a lender to an industry which has been severely buffeted by financial problems for upwards of five years.

Mr. Chairman, we continue to operate in a very difficult environment. The problem today is not the availability of credit. The problem is still the lack of borrower repayment ability. I am absolutely confident that the System is making every loan that has a reasonable chance of repayment. I believe we would be making those loans under more normal conditions, but I am doubly sure it is the case given the intense pressure on loan officers from every quarter within and outside the System to keep credit available. And yet, the System is faced with the need to operate on a sound business basis and to meet the equally important needs of the large majority of System borrowers who are making their payments.

The emerging problem that now threatens the System and all its borrowers is that Farm Credit System institutions' interest rates in many areas are becoming noncompetitive. As the volume of non-earning loans and acquired properties increases, our ability to be competitive decreases. All of these factors--including lingering concerns about System viability--have caused some financially-strong, long-time borrowers to move their credit business elsewhere.

Faced with the financial stress in the System, the financial stress in agriculture and with no prospects for immediate improvement in farm income, we have faced three choices over the past few months: to watch this cooperative lending system become nonviable one institution at a time; to come to the door of the Federal government with our hands outstretched for Federal dollars to help us become competitive once again; or to do some serious soul-searching, then take steps to re-establish the Farm Credit System on a sound business basis for the long term.

Mr. Chairman we have made the decision to move forward and make every effort to manage our problems internally. We believe that strategy is consistent with the central theme of the 1985 Amendments.

Implementation of The Farm Credit Amendments Act

The System is moving deliberately to implement the 1985 Act as swiftly as possible:

o Districts and associations have notified borrowers of the respective institution's forbearance policy, access to borrower's loan documents, and the institution's corporate articles and bylaws.

o New loan review committees are being established and implemented in each district.

o Districts have begun the process of notifying borrowers whose loans are classified as non-accrual and determining whether they can qualify for restructuring as a result of the '85 Act.

o Districts have developed a philosophy for working with the new Capital Corporation and the new FCA Board.

o FCA has chartered the new Capital Corporation and it has succeeded fully to the assets of its predecessor Capital Corporation.

o The System is proposing a draft financial plan for recommendation to the Capital Corporation Board. We hope that this plan could form the basis by which the Capital Corporation would mobilize System resources to aid troubled System institutions.

o The System has accomplished the election of its members on the Capital Corporation Board.

o The System has responded to FCA's emergency regulations on the organization and governance of the Capital Corporation. A copy of our comments is provided to the Subcommittee for the record.

We eagerly await FCA's appointment of two additional directors to the Capital Corporation Board in order that an organizational meeting can be held and operations begun at the earliest possible moment. Though we are optimistic that appointments will occur in the very near future, the System-elected directors nevertheless feel obliged to set the new Corporation in motion and have indicated their intention to proceed with an organizational meeting of the Board no later than May 1st, with or without the FCA-appointed directors.

A New Direction For Farm Credit

Beyond mere implementation of the 85 Amendments, System leadership has, over the past several weeks confronted a number of fundamental issues facing the System. The Presidents of the 37 Farm Credit Banks unanimously approved and System directors recommended to the Board of the Farm Credit Corporation of America, as the umbrella policy-making body of the Farm Credit System, several important resolutions. All have been adopted and copies are attached to my written statement. Let me highlight four key resolutions.

1. **The System will continue to press for quick implementation of the Farm Credit Amendments Act of 1985.**

2. **The System will develop a business plan to return the farmer-owned Farm Credit System to long-term profitability, and not to simply prepare for the day when we seek Federal financial help.**

3. **The System will implement a new pricing philosophy to achieve more competitive interest rates.** To better assure long-term profitability, and therefore, financial viability, the Farm Credit System must price its products and services to farmers, ranchers and cooperatives on a locally-competitive and differential basis, considering risk and costs incurred. Like any other financial institution, we must be able to retain our best farmer and cooperative borrowers and pursue marketing strategies which will attract new credit-worthy farmers, ranchers and cooperatives.

Differential rates are not new. Loans which require the least servicing and are the most secure often receive lower rates, while loans which have the greatest risk and weak repayment ability are usually more costly. Ultimately, this benefits everyone. Mr. Chairman, you can expect that we will be doing everything that we can bring interest rates to a more competitive level!

4. **The Farm Credit System is clearly on record that loan restructuring is the preferred alternative for working with troubled borrowers.** Foreclosure is the last alternative and the least preferred.

We recognize that a major element of our credibility with borrowers is directly linked to our ability to help those farmers who are having the most difficulty making payments. Contrary to what you often read, the decision to foreclose on a farmer is not a decision easily or quickly made by any of our farmer-board members of any Farm Credit System institution.

It is on this basis that the Farm Credit System--its banks and associations--are making the commitment to administer troubled loans to farmers with the objective of utilizing all measures, including FmHA guarantees and participation in Federal or state-funded interest-rate buy-down programs as preferred alternatives to foreclosure.

Like any decision made by the associations and banks of the Farm Credit System, restructurings must be undertaken on a case-by-case basis. Let's first understand Mr. Chairman, that to the extent that restructuring implies forgiveness of principal or interest, we're talking about giving away the capital of other farmer-owners. They won't object to this as long as it is done on a sound business basis. We will pursue restructuring alternatives when:

o The borrower has acted in good faith to manage his business affairs,

o The borrower can present a plan which demonstrates realistic prospects of getting through current financial stress for a return to financial viability,

o The restructuring will minimize any losses which must be borne by other farmer/borrower/stockholders of the bank or association.

What I have just outlined is a tall order for any institution which has incurred record losses, but it is not impossible. It will take cooperation in several key areas and a belief that farmers and their Farm Credit System will survive the current economic straits.

From a recent poll of the Farm Credit districts we know that System entities intend to participate in the FmHA interest rate buy-down program, authorized in the 1985 Farm bill. We know that they are more aggressively seeking to utilize the FmHA loan guarantee program. They are conducting joint training sessions with FmHA, and many have assigned one or more staff to work full-time with FmHA on ways to improve the delivery of their programs to System institutions. Two thirds of the nation's production credit associations have qualified as FmHA Approved Lenders.

Mr. Chairman, several legislative proposals before the Committee seek to encourage agricultural lenders to go even further to forebear, to restructure loans and to forgive debt owed by their farmer/borrowers. It is a simple fact, we have limited resources which we are stretching as far as we can. With taxpayer support, with the commitment of Federal dollars to assisting in lowering interest rates to farmers clearly more restructuring could be accomplished. How much additional restructuring depends on how much the Congress is willing to commit. Every loan decision is made on a case-by-case basis, taking into consideration all options and alternatives available. If

you provide us a new tool, I assure you that we will do our best to use it to the extent our regulator will permit it.

Finally, Mr. Chairman, let me comment on another major concern to the System. At present, the System and the FCA are in the process of establishing a new arms' length relationship as was intended in the 1985 Act. Yet FCA retains most of the long-standing authorities which have permitted the agency to direct the management affairs of the System over the years. We are committed to working with agency officials to bring about FCA's withdrawal from System operations. Specifically, System institutions must have the flexibility to set their own interest rates. At present, no interest rate changes can be made by a district without FCA approval.

As a result of a February 14, 1986 memorandum from FCA, entitled "Capital Directive No. 1," FCA considers the current capital of banks and associations of the System to be "at the level of minimum adequacy under existing circumstances..." and that "any action ....that has the effect of dissipating the institution's existing capital resources, decreasing its revenues, or otherwise diminishing its capacity to provide financial assistance to other institutions" is prohibited.

The effect of this directive is that every institution in the System now has questions about the extent to which FmHA programs and other restructurings can be undertaken, or whether any state interest buy-down programs can be used.

Mr. Chairman, we will continue to press for FCA's withdrawal from this and other management aspects of System operations to achieve Congress' intention to establish more credible regulation of System institutions.

In summary, Mr. Chairman, I find among the officers and directors of the Farm Credit System, at present, a very strong commitment to fully and swiftly implement the Farm Credit Amendments Act of 1985 and use the tools which the Congress provided through that legislation. We heard the Congress tell us to operate the System on a business-like basis but with the expectation that we will deal with compassion toward those who have no reasonable prospect for financial viability. With the required FCA approvals of needed interest rate reductions, we plan to move aggressively to implement a new pricing philosophy that will enable the System to once again be interest rate competitive. I find a dedication to pursuing every reasonable alternative to remain with troubled borrowers and to vigorously pursue opportunities for greater participation in FmHA guarantee programs and in loan restructuring as the preferred alternatives to foreclosure.

Mr. Chairman, farmers and their lenders are faced with the most difficult situation they have faced since the Depression. The challenge before the System is to work through the most troubled loans, loan by loan, in an attempt to help as many of our farmer/borrowers through this difficult transition as we possibly can while striving to maintain the System as a sound, dependable, and competitively viable provider of credit and related services to U.S. agriculture for the future.

Again, for The Farm Credit Council, I appreciate the opportunity to appear before this Subcommittee. I will be pleased to respond the Subcommittee's questions.

(Attachment follows:)

RESOLUTION #1

Through FCCA, the Farm Credit System will:

A. Develop a business plan to return the system to profitability.

B. Continue to press for prompt implementation of provisions of the Farm Credit Amendments Act of 1985.

C. Further develop and improve the system's financial reporting and forecasting capabilities, including uniform assumptions on systemwide variables.

D. Monitor and communicate system financial conditions and projections to appropriate publics.

E. Develop contingency plans for the system under a variety of assumptions, including federal assistance.

RESOLUTION #2

The Farm Credit System will develop a constructive relationship with FCA which will:

A. Allow FCA to carry out its responsibilities as an arm's-length regulator.

B. Minimize the cost of regulation to the Farm Credit System, its owners and borrowers.

C. Maximize the ability of the system to manage its affairs and return to long-term profitability.

In keeping with the above objectives, FCCA will coordinate systemwide responses to FCA regulations and practices. FCCA and the Farm Credit Council shall work on the system's behalf with FCA and the Congress where necessary to reduce the growing regulatory reporting and operational approval burden on system banks and associations, while actively promoting the use of uniform accounting, reporting, financial and credit practices throughout the system.

RESOLUTION #3

To retain market share and restore long-term profitability, the Farm Credit System will price its products and services on a locally competitive and differential basis considering risk and costs incurred.

FCCA shall develop model pricing programs to accomplish the above objective.

FCCA shall work, on behalf of the system, to obtain FCA approval of model pricing programs and to achieve implementation of such programs in each district.

FCCA shall catalog those products and services and those programs for competition surveillance which have proven successful in various districts and make such information available to all districts.

RESOLUTION #4

The Farm Credit System should endorse and adopt the credit standards adopted by the FCCA board to ensure sound and constructive credit extension and administration throughout the FCS. It is recognized that not all institutions can immediately comply with all standards, but it shall be the system's intent to achieve these standards over time, consistent with agricultural and operating conditions.

The system recognizes that successful performance in credit extension and management is beneficial both to borrowers and to their institutions to ensure reasonable cost of credit to borrowers over time.

FCCA shall monitor and report the performance of each district's compliance with system credit standards and assist districts reach the credit standards as appropriate.

RESOLUTION #5

It is the desire and intent of the Farm Credit System to maintain the long-run financial integrity of the system through effective credit and business practices. To this end, the system will establish and aggressively pursue marketing strategies with competitive policies and practices to attract and retain credit-worthy customers, recognizing that borrowers can best be served if the system maintains and enhances its strength by extending credit on a sound and constructive basis.

Recognizing the success of our efforts is dependent on the implementation of our programs, we express appreciation to all current Farm Credit employees for their dedication and efforts during this difficult period. FCCA shall develop and propose programs to assist districts improve marketing, member-borrower relations and employee morale.

RESOLUTION #6

To better manage interest-rate risk and protect system profitability, the Funding Corporation and FCCA shall develop programs which will provide the system continuous access to funding, at a wide range of maturities. The Funding Corporation shall also analyze and develop strategies to assist the banks in reducing the cost of funds.

RESOLUTION #7

The banks and associations of the Farm Credit System will administer troubled accounts with the objective of utilizing FmHA loan guarantees and other loan restructuring measures, including participation in federal- and state-funded interest rate buy-down programs, as preferred alternatives to foreclosure.

Restructuring should be accomplished on a case-by-case basis when:

* The borrower has acted in good faith to manage his business affairs and has been cooperative with the bank or association;

* The borrower can present a plan with reasonable assumptions showing a high probability of return to financial viability as a result of the restructuring; and

* The alternative chosen will minimize any loss that will be borne by the other borrowers/stockholders of the bank or association.

FCCA shall develop:

* systemwide guidelines and definitions for the restructuring of troubled loans;

* systemwide guidelines and definitions for the management and disposition of acquired property; and

* reasonable means of monitoring and reporting district efforts in the restructuring of loans and the management of acquired property;

FCCA and the Farm Credit Council shall communicate system efforts in this regard to appropriate publics.

RESOLUTION #8

FARM CREDIT SYSTEM MISSION

The Farm Credit System will be the nation's premier provider of credit and financial services to farmers, ranchers, cooperatives and other eligible entities.

FARM CREDIT SYSTEM STRATEGIC OBJECTIVES

The Farm Credit System will:

1. Be a dependable source of high-quality, financial and credit-related services to all qualified customers.

2. Price products on the basis of competition, risk incurred and cost of delivery.

3. Maximize efficiency and effectiveness in the delivery of products and services and in the management of human and physical resources.

4. Maximize long-term profitability to support growth, strengthen the system's capital base, and provide a competitive return on owners' investment.

5. Assess, manage and control credit, interest-rate and liquidity risk.

FCCA shall develop a systemwide strategic plan and an operational business plan in accordance with the above Mission Statement and Strategic Objectives.

STATEMENT OF THE

AMERICAN COUNCIL OF LIFE INSURANCE

Statement Made By:

Leslie G. Horsager
Vice President
Prudential Insurance
Company

Mr. Chairman and Members of the Subcommittee, I am Les Horsager, Vice President, the Prudential Insurance Company. The following testimony is submitted on behalf of the American Council of Life Insurance ("ACLI"). The ACLI is a trade association with a membership of 629 life insurance companies. In the aggregate these companies account for approximately 95 percent of the life insurance in force in the United States and hold 96 percent of the assets of insured pension plans.

Background

The life insurance industry is a provider of agricultural real estate financing of long standing. Many of the life insurance companies providing capital to agriculture today have been doing so for more than 100 years. Farm mortgages make a positive contribution to a well balanced investment portfolio. Insurance companies are familiar with the risks and rewards of farm lending.

The life insurance industry presently has just over $12 billion outstanding in mortgages secured by agricultural real estate, and, in addition, a significant amount is invested in agriculturally related businesses through bond and common stock holdings. It is our desire to continue that investment experience and to utilize our staff and infrastructure that has been carefully developed over the past century to provide private capital to

agriculture on competitive terms. The life insurance companies have a successful record of perseverance and dependable service to agricultural finance through good times and bad. We continue to support our respective portfolios of farm assets in an atmosphere of unrestricted, healthy, and efficient competition. We have taken risks and enjoyed the rewards. We have also suffered losses. Investment in American agriculture by private enterprises has always been a healthy and much needed activity for the agricultural borrower.

The Current Situation

Our industry is active in nearly every major farm state. New mortgages continue to be made today even in the face of the current agricultural situation. This further serves to demonstrate the commitment of the industry to provide capital to agriculture, as well as indicate that qualified and credit-worthy borrowers are able to obtain financing.

Life insurance companies' agricultural loan portfolios are not without problems. At the end of 1984, there was approximately $1.2 billion or 10% of the loans by volume delinquent or in foreclosure. This compares with $240 million or 2% in 1980. In 1984, insurance companies acquired by foreclosure or involuntary conveyance just over $250 million in agricultural property. Preliminary indications suggest that these numbers will be higher in 1985.

The continued decline in the prices of agricultural commodities and assets and the uncertainty in credit markets contribute to the decline and instability of the agricultural sector. It also discourages new investment, increases the cost, and reduces the volume of credit that is available. This deterioration of the markets, together with the financial stress on the agricultural sector, is expected to continue in the near term and will negatively impact:

* Federal, State and Local tax revenues
* Infrastructure of the food production system
* Services available in rural communities
* Businesses that merchandise, process or market agricultural products
* Agricultural credit sources

Widespread media coverage and public attention is being focused on the "Farm Credit Crisis." The Congress recently enacted the "Farm Credit Amendments Act of 1985" (P.L. 99-205) to reorganize and rescue the Federal Farm Credit System. While we believe strongly in preserving the financial integrity of the Farm Credit System, we are also concerned about the ability of other agricultural lenders to continue to participate in the industry.

The availability of several alternative sources of credit assures efficient and competitive markets for agricultural credit.

A disadvantageous position imposed upon private lenders will discourage new sources of capital from entering the agricultural credit market, and encourage an exodus of those now active in providing credit. Any program designed to stabilize the agricultural credit industry over the long term must seek to insure continued private lender participation.

We hope and expect that if taxpayer assistance given the Farm Credit System ameliorates the pressures on Farm Credit System borrowers, equal benefit will be available to non-Farm Credit System borrowers. The proposal for an interest rate buydown program as provided by H.R. 3868 deals realistically with the problems using participation from both private and public sector institutions. We strongly support these types of programs and believe they are a significant step towards dealing with today's problems.

The Long Term

In the long run, American agriculture should be a full participant in various American capital markets. We believe that this is clearly in the best interests of agriculture, of the taxpayers and of the nation in general. The alternative is that American agriculture increasingly becomes a ward of the Federal government as to its credit needs.

We believe that competition and market discipline can be restored in the agricultural credit industry. To do so requires a healthy private sector lending capability. In our view, private lenders could compete, despite the pricing edge of government agencies, if there was adequate liquidity for their investment portfolios. While insurance companies may currently have a need for long-term farm mortgage investments, portfolio managers are reluctant to acquire significant amounts of these investments without assurances that they can be remarketed as their investment portfolios need rebalancing.

Liquidity has been provided in other long-term mortgage investments, such as the residential mortgages, by the development of a secondary market in these investments. It should be noted, however, that these secondary markets developed only after government-sponsored agencies provided mortgage insurance as well as standardization within the industry. With an extensive secondary market for such mortgages, life insurance companies are once again major mortgage investors to the benefit of many home buyers.

Insurance companies believe the same concept should be developed in the agricultural mortgage business. If sufficient liquidity could be established through a secondary market for agricultural mortgages, our companies would be able to increase their participation as a major provider of long-term capital to agriculture, thereby increasing farmers' access to the nation's major capital markets. Just as homeowners in small communities throughout the

nation have been served by the development of a secondary market for residential mortgages, farmers throughout the country would benefit from the development of a secondary agricultural mortgage market.

We believe American agriculture would benefit greatly from increased availability of private sector financing. The major advantages of private sector participation are several:

1. The private sector is enormous and highly diversified. Diversified sources of credit assure safety for farmers and investors alike.

2. The private sector is innovative and fiercely competitive. Such features have historically acted to the benefit of its customers.

3. The private sector could promote the development of a secondary market for agricultural mortgages thereby providing a method to recycle capital from the major capital markets back into rural areas.

A basic feature of private sector financing is that its interest rates and terms are, at all times, reflective of the current capital markets. Some will say commercial agriculture cannot afford financing at commercial rates and terms. This is, in our experience, not the case. Realistic interest rates encourage

realistic borrowing and provide an on-going discipline for all enterprises that use borrowed capital.

Given the tendencies of land prices to appreciate excessively when below-market financing is available, it can be asserted that in the long run agricultural assets will be more soundly priced and valued if interest rates are at commercial market levels. Viewing the last ten years, this would certainly have been a blessing to all concerned.

We believe American agriculture would benefit greatly with increased availability of private sector financing. Indeed, what agriculture needs is direct access to today's capital markets where interest rates have dropped significantly in recent months. Clearly, the American taxpayer would benefit in two ways. First, most private sector sources are subject to Federal income taxation on their investment income. Second, the possibilities of a repetition of this current demand for massive bailout would be materially reduced since sources of agricultural credit would be spread more diversely amongst investors.

For these reasons, we recommend that an equitable treatment of all agricultural lenders be established as a matter of on-going public policy. We also recommend that Congress seriously consider proposals to enhance liquidity for agricultural mortgages through the development of a secondary market. Our companies are currently developing a plan in conjunction with other farm lenders through

which long-term agricultural lenders can enjoy more liquidity in their loan portfolios and thereby increase the share of private capital invested in American agriculture. We believe this will result in greatly increased private sector participation to the betterment of both lenders and borrowers.

STATEMENT OF THE AMERICAN FARM BUREAU FEDERATION
BEFORE THE SUBCOMMITTEE ON CONSERVATION, CREDIT AND RURAL DEVELOPMENT
HOUSE AGRICULTURE COMMITTEE
WITH REGARD TO AGRICULTURAL CREDIT

Presented by

Dean Kleckner, President, American Farm Bureau Federation

April 9, 1986

Mr. Chairman, Farm Bureau appreciates the opportunity to testify today on agricultural credit.

I am Dean Kleckner, President of the American Farm Bureau Federation and a farmer from Rudd, Iowa. I operate a 550 acre farm where we produce corn and soybeans as well as raising and marketing about 1,800 hogs annually.

For the past five years, agricultural finance policy has been driven by the "one more year" syndrome. The goal has been to keep borrowers and lenders solvent for one more year hoping that the debt/income situation would correct itself. Since farm operators and lenders are partners and one cannot survive without the other, actions were taken on the assumption that anything that would help one would help the other.

This "one more year" policy was based on the idea that the debt problems of agriculture were caused primarily by forces beyond the control of the farm operator. Once these outside forces, such as high interest rates, a strong dollar, low exports, declining land prices and high production costs went back to "normal," everything would be fine. These outside forces were contributing factors, but not at the root of the debt problems and changes in these forces will not eliminate the debt pressures.

Agriculture has run out of "one more years." As a policy, that approach is now obsolete. Those short-term lenders who have loaned money on equipment and livestock to pay interest and principal on land have said, "No more." Most operators are reluctant to further mortgage land to cover unpaid operating expenses.

Operators with the greatest debt problems have substantial amounts of nonworking debt that require the servicing of principal and interest but provide little, if any, cash flow to the business.

For 1986, the agricultural finance policy debate has been focused on the immediate problems of the one-third of commercial agricultural operators that hold two-thirds of the debt held by all farm operators. About half of this group, 100,000 to 125,000 farm operators, are at the point where substantial debt restructuring will be needed over the next two years to avoid liquidation, either voluntary or forced.

A substantial reduction in debt load or a reduction in the debt that has to be serviced out of current income is absolutely essential. Only this will bring long-lasting financial relief to stressed farm

operators. For some portion of the farm operators, no reasonable amount of debt relief will be sufficient to deal with their debts.

Several months ago, Farm Bureau set out to develop a debt restructuring plan to aid financially stressed farmers who, under the right circumstances, have the chance to survive.

The American Farm Bureau Federation has proposed a Two-Tier Debt Restructuring Program to deal with long-term financial problems.

The program would start with the farm operator and the lender analyzing the individual operation to determine how much debt could be paid under normal circumstances. That would become Tier 1 debt. On this Tier 1 portion of the debt, the farm operator would pay the regular interest and principal payments over 10 to 20 years. The remainder of the debt would be put into Tier 2, where it would carry an interest rate of 3 percent with no principal payments. As a portion of the Tier 1 debt is paid off annually, debt would shift from Tier 2 to Tier 1 until all the two-tier debt is paid.

For example: A farmer has a $300,000 debt, and after an analysis, the lender and the farmer decide that $200,000 can be properly serviced; that becomes Tier 1 and the remaining $100,000 becomes Tier 2 debt. The key is debt restructuring--not debt forgiveness.

Some steps are necessary to make the program work. Tier 2 debt must be monitored separately by regulatory authorities so that it is not discriminated against or classified against the capital of the financial institution.

Let me say at this time that we are pleased that the banking regulators have made two-tier debt restructuring, as well as other forms of debt restructuring, possible through issuing new regulations. As of March 28, the Federal Deposit Insurance Corporation, the Federal Reserve System and the Comptroller of the Currency had sent notices to their banks to employ a common set of general supervisory policies to assist troubled banks. These policies included capital forbearance, changes in the call report requirement, and a reaffirmation of the use of Financial Accounting Standards Board Rule #15. FASB 15 simply says that a loan may continue to be carried on a bank's books without any loss recognition if the loan is restructured in a manner so that it is probable and estimable that the borrower can repay the loan under the new terms, and that the total future cash payments by the borrower (principal and interest combined) at least equals the loan amount on the bank's books. Therefore, our two-tiered debt restructuring proposal would be available for a bank's use since no debt is forgiven.

Let me emphasize that we believe that the new regulations issued by the three bank regulators, along with the reaffirmation of use of FASB 15, could aid a high percentage of debt-ridden farmers. I think most would agree that the regulators would not have taken these steps had not Congress, Farm Bureau, and a few other groups put pressure on them to do so.

## VI. ABUSES

Spokesmen for the U.S. Postal Service, the Federal Trade Commission, consumers and several insurance commissioners have indicated that there are widespread abuses by elderly. These abuses are allegedly so prevalent that they have spawned their own vocabulary. This section of this questionnaire is to ask if you have ever received complaints of any of the following practices:

| | NO | YES |
|---|---|---|
| 1. **"Wolf in sheep's clothing"** - the agent fails on initial contacts with clients to disclose that he represents a for-profit insurance company. He may say he is from Medicare and wants to help seniors with any problem they may have. | | |
| 2. **"Overselling"** - the agent sells the clients more coverage than they need or can pay for or both (e.g. loss of employment capability for a retired individual) | | |
| 3. **"More is better"** - the agent represents that his policy which has a higher premium thanthe competition is better simply because of higher premium. | | |
| 4. **"Duplicate sales"** - the agent sells the client additional policies which in effect client. | | |
| 5. **"Group policy"** - the agent represents the policy as a group policy with the implication that premiums are less when in fact there is no group and the policy is the same in coverage and premium as a regular policy. | | |
| 6. **"Clean sheeting"** - (or failure to report material condition") - the agent fails to report preexisting health conditions of clients to company, ultimately leading to a pre-existing condition disqualification of coverage when claims are filed. | | |
| 7. **"Just dropped by"** - the salesman claims to stop by the client's home to collect premiums, but actually solicits new business. | | |
| 8. **"' work with . . ."** - the licensed salesman allows an unlicensed person to front for him. | | |
| 9. **"Pie in the sky"** - (or "fine print") - the agent misrepresents policy content with words like "no waiting periods," "this policy will pay for everything," etc. | | |
| 10. **"Forgery"** - the agent either signs someone's name to the insurance forms or encourage the elderly client to illegally sign name of insured loved one. | | |
| 11. **"The Switch"** - the agent sells the client one policy but then switches and provides another for signature at time of closing. | | |
| 12. **"The add on"** - the agent, after selling one policy includes in the "forms for signature" by the client a second or third policy stating when asked, ". . . you'll need this too." | | |



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| | NO | YES |
|---|---|---|
| 13. **"Low weekly rates"** - the agent quotes premium prices on a weekly basis but closes and sells on an annual basis. | | |
| 14. **"New is better"** - ("Twisting" or "existing policies are garbage") - the agent encourages the client to cancel perfectly good existing policies to sell a new policy which results in additional commission fees. | | |
| 15. **"The stall"** - the agent delays in responding to requests by newly insured to discuss cancellation of policy. Time limits for cancellation are thereby exceeded. | | |
| 16. **"Scare tactics"** - the agent employs scare language in closing the sale like "buy now because you may not be able to be insured later," etc. | | |
| 17. **"Corporate twisting"** - a conspiratorial arrangement whereby two or three companies transfer aged customers between themselves. This results in the expiration of policies which are in force, in favor of newly acquired policies with waiting periods. | | |
| 18. **"The government look"** - agents and/or companies use advertising materials that tend to associate them with the federal Medicare or Social Security program. | | |
| 19. **"The fence post policies"** - the agent completes applications in the name of relatives or others, unknown to the victims. This is done to bypass underwriting rules when it is know the victims already have the maximum coverage in effect with a company. | | |
| 20. **"Make the check out to me"** - the agent asks that the client make the check out to him. The agent then cashes the check, and does not report the transaction to the insurance company. No policy issued. | | |
| 21. **"The Medi-gap bandwagon"** - the agent sells the client additional accident or life insurance as if it were part of a "comprehensive Medi-gap plan." | | |
| 22. **"Postdating application"** - agent postdates application to avoid maximum coverage guidelines. Net result is that client is often not covered for initially agreed period. | | |

23. Others (Please specify)

(189)

24. Others (Please specify)

25. Others (Please specify)



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## VII. INCREASED FEDERAL REGULATION?

1. Would you favor any of the following options increasing the role of Federal regulation in insurance?

   a. Repeal of the McCarran-Fergusson exemption allowing the application of anti-trust laws to the insurance industry? ___No ___Yes

   b. Authorizing the Federal Trade Commission to regulate unfair trade practices and restraint of trade in the industry? ___No ___Yes

   c. Authorizing the Federal Trade Commission to issue minimum standards in the limited area of Medicare supplemental policies? ___No ___Yes

2. An industry spokesman has been quoted as saying that Medicare supplemental policies represent the number one problem currently confronting the State Insurance Commissioners at the present time. Do you agree? ___No ___Yes

   If no, what is your biggest problem at present? _____

   _____

   _____

## VIII. REQUEST FOR FURTHER INFORMATION

1. Will you please provide the Committee with three case histories of complaints with respect to Medicare supplemental policies that were resolved by your office? Please feel free to delete names of individuals or agents if you would so desire.

2. Has your state produced any pamphlets or literature addressed to senior citizens providing guidance with respect to Medicare supplemental policies? ___No ___Yes

3. May we have a copy of your latest annual report?

4. Please send in a copy of your resume (and that of your predecessor, if available) in order to aid in our poll of the background and qualifications of State Commissioners.

## OUR SINCERE THANKS FOR YOUR HELP

Would you like to testify before the House Select Committee on Aging? ___Yes ___No

Please return this questionnaire, along with additional requested information, no later than February 1, 1983 to:

Select Committee on Aging
Subcommittee on Health and Long-Term Care
Room 715, House Annex #1
Washington, D.C. 20515



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APPENDIX B

# U.S. House of Representatives

SELECT COMMITTEE ON AGING
SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE
377 House Office Building Annex 2
Washington, DC 20515

## QUESTIONNAIRE ON REGULATION OF HEALTH AND MEDICARE SUPPLEMENTAL POLICIES
(ABBREVIATED VERSION
MARCH 1986)

1. What is the budget for your office this year? _____ What was it in 1985? _____
2. What is the total number of full-time equivalents employed by your office? _____ How many clerical? _____ How many professionals? _____
3. Of the above number, how many professionals make up your investigative staff? _____ How many investigators do you presently have assigned to health insurance complaints? _____
4. What is the total dollar volume of all premiums paid for all kinds of insurance in your State for 1985 or most recent year? _____.
5. How many accident/health insurance policies or changes in existing policies did your office review in 1985?_____
6. How many licensed agents do you have in your State? _____
7. How many are licensed to sell health/accident insurance? _____
8. How many agents have had their licenses revoked for abuses related to the sale of accident/health insurance in the last year? _____ _____
9. How many of this total number were reinstated and later allowed to sell insurance in your State? _____
10. We have heard of some cases where agents were paid more than 100 percent of annual premiums in commission. Do you have regulations which limit the amount of commissions that agents may receive? _____Yes _____No
11. Has your office issued regulations covering the following aspects of health insurance policies in general (and Medicare supplemental policies in particular) as taken from the NAIC Model bill:

| | NO | YES |
|---|---|---|
| a. Terms of renewability | _____ | _____ |
| b. Initial and subsequent conditions of eligibility | _____ | _____ |



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| | | | |
|---|---|---|---|
| c. | Non-duplication of coverage provisions | ____ | ____ |
| d. | Readability (clear language instead of legalese) | ____ | ____ |
| e. | Size of print | ____ | ____ |
| f. | Pre-existing conditions | ____ | ____ |
| g. | Termination of insurance | ____ | ____ |
| h. | Probation periods | ____ | ____ |
| i. | Limitations | ____ | ____ |
| j. | Exceptions | ____ | ____ |
| k. | Reductions | ____ | ____ |
| l. | Eliminations | ____ | ____ |
| m. | Requirements for replacements | ____ | ____ |
| n. | Recurrent conditions | ____ | ____ |
| o. | The definitions of such key terms as: hospital, accident, injury, physician, accidental means, total disability, nervous disorder, guaranteed renewable and non-cancellable | ____ | ____ |
| p. | Require that the prospective purchase be given a form showing coverage available under Medicare and Medicaid and how the policy would fill the gaps | ____ | ____ |
| q. | Cancellation of entire policy groups | ____ | ____ |
| r. | Minimum coverage requirements | ____ | ____ |
| s. | Limits on exclusions of pre-existing conditions | ____ | ____ |
| t. | Disclosure requirements | ____ | ____ |
| u. | Refund requirement | ____ | ____ |
| v. | Statement of major benefit gaps in Medicare Parts A and B, with a parallel description of supplemental benefits. | ____ | ____ |

12. Do you have regulations relating to the use of pre-existing condition clauses in Medicare supplemental policies? ___Yes ___No

If yes, do these regulations

___a) eliminate pre-existing conditions clauses

___b) shorten the precondition period to 2 years

___c) shorten the period to 12-23 months

___d) shorten the period to 6 months

___e) require that language relating to pre-existing conditions to be printed prominently on the application form

___f) apply only to policies sold by mail



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13. Do you have mandatory review procedures for advertisements which relate to insurance policies sold by mail? ____Yes ____No

14. Does your State have minimum loss ratios for various classes of health insurance policies? ____Yes ____No Are they mandated by law____, regulation____, or in guidelines____?

    What is your minimum loss ratio for Medicare supplemental policies?_____

    What action can you take if a company exceeds minimum ratios?_____

15. Does your State mandate a no-loss right of cancellation clause to Medicare supplemental policies? ____Yes ____No

16. How many complaints has your office received in 1985? _____

17. How many of these complaints relate to accident/health insurance? _____

18. How many insurance companies have been fined or otherwise disciplined over the past three years for violations or abuses with respect to the sale of health insurance? ____Please supply names and disposition of cases.



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19. Spokesmen for the U.S. Postal Service, the Federal Trade Commission, consumers and several insurance commissioners have indicated that there are widespread abuses of elderly customers by persons selling supplemental Medicare insurance. These abuses are allegedly so prevalent that they have spawned their own vocabulary. This section of this questionnaire is to ask if you have ever received complaints of any of the following practices:

| | NO | YES |
|---|---|---|
| 1. **"Wolf in sheep's clothing"** - the agent fails on initial contacts with clients to disclose that he represents a for-profit insurance company. He may say he is from Medicare and wants to help seniors with any problem they may have. | | |
| 2. **"Overselling"** - the agent sells the clients more coverage than they need or can pay for or both (e.g. loss of employment capability for a retired individual) | | |
| 3. **"More is better"** - the agent represents that his policy which has a higher premium thanthe competition is better simply because of higher premium. | | |
| 4. **"Duplicate sales"** - the agent sells the client additional policies which in effect client. | | |
| 5. **"Group policy"** - the agent represents the policy as a group policy with the implication that premiums are less when in fact there is no group and the policy is the same in coverage and premium as a regular policy. | | |
| 6. **"Clean sheeting"** - (or failure to report material condition") - the agent fails to report preexisting health conditions of clients to company, ultimately leading to a pre-existing condition disqualification of coverage when claims are filed. | | |
| 7. **"Just dropped by"** - the salesman claims to stop by the client's home to collect premiums, but actually solicits new business. | | |
| 8. **"I work with . . ."** - the licensed salesman allows an unlicensed person to front for him. | | |
| 9. **"Pie in the sky"** - (or "fine print") - the agent misrepresents policy content with words like "no waiting periods," "this policy will pay for everything," etc. | | |
| 10. **"Forgery"** - the agent either signs someone's name to the insurance forms or encourage the elderly client to illegally sign name of insured loved one. | | |
| 11. **"The Switch"** - the agent sells the client one policy but then switches and provides another for signature at time of closing. | | |
| 12. **"The add on"** - the agent, after selling one policy includes in the "forms for signature" by the client a second or third policy stating when asked, ". . . you'll need this | | |



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| | NO | YES |
|---|---|---|
| 13. "Low weekly rates" - the agent quotes premium prices on a weekly basis but closes and sells on an annual basis. | | |
| 14. "New is better" - ("Twisting" or "existing policies are garbage") - the agent encourages the client to cancel perfectly good existing policies to sell a new policy which results in additional commission fees. | | |
| 15. "The stall" - the agent delays in responding to requests by newly insured to discuss cancellation of policy. Time limits for cancellation are thereby exceeded. | | |
| 16. "Scare tactics" - the agent employs scare language in closing the sale like "buy now because you may not be able to be insured later," etc. | | |
| 17. "Corporate twisting" - a conspiratorial arrangement whereby two or three companies transfer aged customers between themselves. This results in the expiration of policies which are in force, in favor of newly acquired policies with waiting periods. | | |
| 18. "The government look" - agents and/or companies use advertising materials that tend to associate them with the federal Medicare or Social Security program. | | |
| 19. "The fence post policies" - the agent completes applications in the name of relatives or others, unknown to the victims. This is done to bypass underwriting rules when it is know the victims already have the maximum coverage in effect with a company. | | |
| 20. "Make the check out to me" - the agent asks that the client make the check out to him. The agent then cashes the check, and does not report the transaction to the insurance company. No policy issued. | | |
| 21. "The Medi-gap bandwagon" - the agent sells the client additional accident or life insurance as if it were part of a "comprehensive Medi-gap plan." | | |
| 22. "Postdating application" - agent postdates application to avoid maximum coverage guidelines. Net result is that client is often not covered for initially agreed period. | | |

23. Others (Please specify)

24. Others (Please specify)

25. Others (Please specify)



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20. Would you favor any of the following options increasing the role of FEderal regulation in insurance?

    a. A bill to increase the penalties of the Federal Mail Fraud Statute for each count of mail fraud from $1,000 to $10,000 and from five years to 15 years?

    ___No ___Yes

    b. A bill to expand current benefits under Medicare to include coverage for dental care, hearing and eye care, preventive check-ups and long-term nursing home or home care, in effect abolishing the need for Medigap insurance?

    ___No ___Yes

21. An industry spokesman has been quoted as saying that Medicare supplemental policies represent the number one problem currently confronting State Insurance Commissioners. Do you agree?

    ___No ___Yes

    If no, what is your biggest problem at present?_____

    _____

    _____

22. Will you please provide the Subcommittee with three case histories of complaints with respect to Medicare supplemental policies that were resolved by your office? Please feel free to delete names of individuals or agents if you so desire.

23. Has your State produced any pamphlets or literature addressed to senior citizens providing guidance with respect to Medicare supplemental policies? ___No ___Yes

24. May we have a copy of your latest annual report?

**OUR SINCERE THANKS FOR YOUR HELP**

Would you like to testify before the House Select Committee on Aging, Subcommittee on Health and Long-Term Care? ___Yes ___No

Please return this questionnaire, along with additional requested information, no later than April 15, 1986, to:

Subcommittee on Health and Long-Term Care
House Annex 2, Room 377
Washington, DC 20515



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APPENDIX C

# U.S. House of Representatives

SELECT COMMITTEE ON AGING

SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE

377 House Office Building Annex 2

Washington, DC 20515

May 23, 1986

CLAUDE PEPPER, FLORIDA
CHAIRMAN

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HAROLD E. FORD, TENNESSEE
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ED BEETLER, MISSOURI
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GLEDDY McCRAY, FLORIDA
NORMAN SISISKY, VIRGINIA
EDWARD R. ROYBAL, CALIFORNIA (EX OFFICIO)

KATHLEEN GARDNER CRAVEDI
STAFF DIRECTOR

MELANIE MADLIN
ASSISTANT STAFF DIRECTOR

PETER SLOCUM
DIRECTOR OF RESEARCH

JAY CONSTANTINE
BILL MALAMUDMEDD
LEWIS H. BUTLER, M.D., D.P.H.
CONSULTANTS

(202) 226-3381

RALPH REGULA, OHIO
RANKING MINORITY MEMBER

GEORGE C. WORTLEY, NEW YORK
JIM COURTER, NEW JERSEY
CLAUDINE SCHNEIDER, RHODE ISLAND
THOMAS J. RIDGE, PENNSYLVANIA
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JIM LIGHTFOOT, IOWA
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PATRICK L. SWINDALL, GEORGIA
PAUL B. HENRY, MICHIGAN
JIM KOLBE, ARIZONA
MATTHEW J. RINALDO, NEW JERSEY (EX OFFICIO)

MARK BENEDICT, J.D.
MINORITY STAFF DIRECTOR

LORI LIGHTFOOT
ASSISTANT STAFF DIRECTOR

(202) 226-3383

Dear AAA Director:

Your assistance with a matter of importance to the House Select Committee on Aging, Subcommittee on Health and Long-Term Care, would be appreciated.

As you may know, the House Aging Committee in 1978 performed an intensive investigation into supplemental Medicare insurance, also known as "Medigap" insurance. At that time flagrant abuses were observed in connection with the sale of these policies. Federal reform measures were enacted shortly thereafter.

Now, after learning of numerous cases of fraud and abuse with Medigap and observing the proliferation of television and mail advertising campaigns for these policies, the Subcommittee on Long-Term Care is reopening its investigation. We are asking for your help.

The attached questionnaire has been designed to measure the knowledge older people have about the basic attributes of health insurance. It also gives us a chance to see how much older persons know about Medicare coverage as it exists under current law.

We would like to ask that you arrange to have the enclosed 26-item questionnaire read aloud and answered at one senior center in the jurisdiction of your area agency on aging. The size of the group will be left to your discretion, although we would remind you that the larger the group, the more representative and thereful more helpful to our survey it will be. (Probably 20 persons would be minimum acceptable size.) We would ask that you make arrangements with the senior center staff promptly, as results are due back to us by June 6, 1986.

I know that the implementation of this survey will require an investment of your time and the time of a senior center staff member but I am confident it will yield results which will prove invaluable to our nation's seniors in search of health security.

Thank you in the warmest way for your assistance.

With kindest regards,

Very sincerely,

Claude Pepper
Chairman

P.S. Should questions arise, kindly contact Melanie Madlin or Kathleen Gardner Cravedi of my Subcommittee staff at (202) 226-3381.



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CLAUDE PEPPER, FLORIDA
CHAIRMAN

JAMES J. FLORIO, NEW JERSEY
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KATHLEEN GARDNER CRAVEDI
STAFF DIRECTOR

MELANIE MODLIN
ASSISTANT STAFF DIRECTOR

PETER BENEDICT
DIRECTOR OF RESEARCH

JAY CONSTANTINE
BILL HALAMANDARIS
LORNE W. FIELDEN, M.D., D.P.H.
CONSULTANTS

(202) 226-3381

U.S. House of Representatives
SELECT COMMITTEE ON AGING
SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE
377 HOUSE OFFICE BUILDING ANNEX 2
Washington, DC 20515

RALPH REGULA, OHIO
RANKING MINORITY MEMBER

GEORGE C. WORTLEY, NEW YORK
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CLAUDINE SCHNEIDER, RHODE ISLAND
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MATTHEW J. RINALDO, NEW JERSEY (EX OFFICIO)

MARK BENEDICT, J.D.
MINORITY STAFF DIRECTOR

LORI LIGHTFOOT
ASSISTANT STAFF DIRECTOR

(202) 226-3983

May 23, 1986

Dear Senior Center Director:

You will please find enclosed a copy of a questionnaire that concerns health insurance and Medicare. This questionnaire has been directed to you by officials at your local Area Agency on Aging.

As you may know, the House Aging Committee in 1978 performed an intensive investigation into supplemental Medicare insurance, also known as "Medigap" insurance. At that time flagrant abuses were observed in connection with the sale of these policies. Federal reform measures were enacted shortly thereafter.

Eight years later, the Committee's Subcommittee on Health and Long-Term Care, which I chair, is reopening its investigation. We would appreciate your help.

We would like to ask that you arrange to read aloud the enclosed 26-item questionnaire before a group of seniors at your senior center in the near future. Group members can raise their hands to signal "True," "False" or "I Don't Know" in response to each question and you can then record the number of responses. The size of the group will be left to your discretion, although I would remind you that the larger the group, the more representative the sample and therefore the more helpful to us the survey will be. (Probably 15-20 persons would be the minimum acceptable size.) The survey should not take much time. Perhaps it could be given during a lunch period, or at the beginning or end of a general meeting or an activity group. I would ask that you return the completed questionnaire on or before Friday, June 6, to:

MEDIGAP SURVEY
Subcommittee on Health
and Long-Term Care
H2-377
U.S. House of Representatives
Washington, DC 20515

I know that this survey will require a small investment of time and energy from you and your senior center participants, but I am confident its results will be invaluable to our seniors in search of health security.

Thank you in the warmest way for your assistance.

With kindest regards,

Very sincerely,

Claude Pepper
Chairman

P.S. Should questions arise, kindly contact Melanie Modlin or Kathleen Gardner Cravedi of the Subcommittee staff at (202) 226-3381.



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## SENIOR CENTER QUESTIONNAIRE

SENIOR CENTER NAME AND ADDRESS: _____

TOTAL NUMBER OF SENIORS SURVEYED: _____

NAME AND TITLE OF PERSON ADMINISTERING QUESTIONNAIRE: _____

DATE ADMINISTERED: _____

### QUESTIONS REGARDING HEALTH INSURANCE

1. A policy that promises to pay a certain amount for each day a person is hospitalized usually provides benefits to a senior citizen that are quite different from the policies designed to pay hospital and doctor expenses that are not covered by Medicare.

   _____ TRUE _____ FALSE _____ DON'T KNOW

2. An indemnity policy which promises to pay a certain amount for each day a person is hospitalized, say $40, typically will not pay more than this amount regardless of how much the hospital, doctor and drug charges are each day.

   _____ TRUE _____ FALSE _____ DON'T KNOW

3. A "pre-existing conditions" clause in a hospital insurance policy means the company can refuse to pay claims due to current illnesses related to or developing from an illness or condition you had when you bought the policy.

   _____ TRUE _____ FALSE _____ DON'T KNOW

4. Some health insurance policies -- known as dread disease policies -- will pay only if the policyholder gets a certain disease covered by the policy such as cancer.

   _____ TRUE _____ FALSE _____ DON'T KNOW

5. Health insurance policies sometimes contain a clause that excludes payment for expenses resulting from certain kinds of illnesses or diseases to certain parts of the body.

   _____ TRUE _____ FALSE _____ DON'T KNOW

6. Policies with a short time period during which claims can be denied due to pre-existing conditions are usually the most advantageous for persons 65 and over.

   _____ TRUE _____ FALSE _____ DON'T KNOW



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7. If a company states that a hospital insurance policy is guaranteed renewable for life, this means the premiums can not be raised to exorbitant levels during the lifetime of the policyholder.

_____ TRUE _____ FALSE _____ DON'T KNOW

8. If a hospital insurance policy states it will pay certain hospital expenses, say so much a day for hospitalization, this means it will always pay for these expenses regardless of the cause of the illness that resulted in hospitalization.

_____ TRUE _____ FALSE _____ DON'T KNOW

9. If a policy states that certain hospital and medical expenses will be paid, the company must pay for these expenses regardless of how much they add up to during a year or during the policyholder's lifetime.

_____ TRUE _____ FALSE _____ DON'T KNOW

10. Generally, it is unwise for persons 65 and over to buy a hospital insurance policy on which the issuing company has a high loss ratio -- where a high percentage of the premiums collected are paid out in claim losses -- because the company in the future may raise premiums, cancel the policy, resist paying claims, or become financially unsound.

_____ TRUE _____ FALSE _____ DON'T KNOW

11. A person who cancels a hospital insurance policy and then immediatley buys another policy will be without full coverage for a period of time because of "pre-existing conditions" and/or "waiting period" clauses in the new policy.

_____ TRUE _____ FALSE _____ DON'T KNOW

## QUESTIONS REGARDING MEDICARE

12. In order to be covered by Medicare medical insurance (Part B), most people 65 and over do not have to pay monthly premiums.

_____ TRUE _____ FALSE _____ DON'T KNOW

13. Medicare hospital insurance (Part A) does not pay for the first $492 of hospital expense incurred by a person in each Medicare benefit period.

_____ TRUE _____ FALSE _____ DON'T KNOW

14. Beginning in the 61st day in a hospital, a person covered by Medicare hospital insurance (Part A) must pay the first $123 per day of hospital expense.

_____ TRUE _____ FALSE _____ DON'T KNOW

15. A person covered by Medicare who is in the hospital longer than 90 days must pay the first $246 per day of hospital expense beginning with the 91st day, and Medicare hospital insurance (Part A) pays the balance until a lifetime total of 60 reserve days of Medicare coverage is used.

_____ TRUE _____ FALSE _____ DON'T KNOW

16. If a person is admitted to a skilled nursing facility following at least a 3-day stay in a hospital, Medicare hospital insurance (Part A) will pay for all covered services for the first 20 days in the nursing facility if certain conditions are met.

_____ TRUE _____ FALSE _____ DON'T KNOW



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17. From the 21st through the 100th day in a skilled nursing facility, Medicare hospital insurance (Part A) helps pay for covered services, but the person must pay the first $61.50 per day of expense for covered services.

_____ TRUE _____ FALSE _____ DON'T KNOW

18. Medicare medical insurance (part B) will pay only what is considered to be a "reasonable" charge or fee. If a doctor or hospital charges more than this amount, the person must pay the difference.

_____ TRUE _____ FALSE _____ DON'T KNOW

19. Medicare medical insurance (Part B) helps pay for outpatient hospital care, outpatient physical therapy and speech pathology services, and home health care which are not covered by Medicare hospital insurance (Part A).

_____ TRUE _____ FALSE _____ DON'T KNOW

20. Medicare medical insurance (Part B) helps pay for doctor's services rendered in his office, in a hospital, in a skilled nursing facility, and in a person's home.

_____ TRUE _____ FALSE _____ DON'T KNOW

21. If a person is an inpatient in a hospital, Medicare medical insurance (Part B) pays 100 percent of the reasonable charges by doctors for services in radiology and pathology.

_____ TRUE _____ FALSE _____ DON'T KNOW

22. Laboratory services and other diagnostic tests, except routine examinations, are covered by Medicare medical insurance (part B).

_____ TRUE _____ FALSE _____ DON'T KNOW

23. Medicare medical insurance (Part B) does not pay for the first $75 of covered or Medicare approved medical expenses in each calendar year.

_____ TRUE _____ FALSE _____ DON'T KNOW

24. Medicare medical insurance (Part B) pays for no more than 80 percent of covered medical expenses, disregarding treatment for mental illness.

_____ TRUE _____ FALSE _____ DON'T KNOW

25. The home health care coverage under Medicare hospital insurance (Part A) and Medicare medical insurance (Part B) may be combined under some circumstances to help pay for more than 100 days of home health care in a calendar year.

_____ TRUE _____ FALSE _____ DON'T KNOW

26. In order for home health care to be covered by Medicare medical insurance (part B), the person must require part-time skilled nursing care or therapy as determined by a doctor and the person must be confined to his or her home.

_____ TRUE _____ FALSE _____ DON'T KNOW

THANK YOU VERY MUCH. PLEASE RETURN THIS COMPLETED TALLY SHEET BY JUNE 6, 1986, TO:

MEDIGAP SURVEY
Subcommittee on Health
and Long-Term Care
House Annex 2, Room 377
U.S. House of Representatives (201)
Washington, DC 20515

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APPENDIX D

April 30, 1985

Honorable Margaret M. Heckler
Secretary
Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Ms. Heckler:

Your attention to a matter of special concern to this Subcommittee would be greatly appreciated.

Over the past several years, I have had a keen interest in the sale of health insurance to the elderly. With the advent of Medicare, private insurers developed supplemental or "Medigap" policies which are designed to cover costs not paid by the government program. Investigations conducted by committees I have chaired previously have identified abuses in the sale of these supplemental policies. The abuses have typically involved objectionable sales tactics and worthless insurance coverages. Hearings have been held on this subject in 1978 and 1981, and legislation has been passed to help curb some of these problems.

I would like to obtain an update in the issue of fraudulent insurance sales to the elderly and I request your assistance in providing details of any investigations you have undertaken in this area since 1981. Please include a description of the scheme, the number of victims, the amount of monetary loss and the outcome of any prosecutive action (e.g., verdict, sentence).

This information should reach me by May 17, 1985.

Thank you for your assistance.

With kindest regards,

Sincerely,

Claude Pepper
Chairman

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APPENDIX E-1

PREMIUMS--CLAIMS--LOSS RATIO
RANKING BY PREMIUM (DESCENDING)

| COMPANY | PREMIUMS EARNED LESS DIVIDENDS (DOLLARS) | CLAIMS INCURRED (DOLLARS) | LOSS RATIO |
|---|---|---|---|
| PRUDENTIAL INS. OF AMER. | 2,702,628,771 | 2,099,725,986 | 78% |
| CONNECTICUT GENERAL LIFE | 1,996,942,214 | 2,842,863,656 | 142% |
| AETNA LIFE INS. CO. | 1,957,669,157 | 1,390,371,505 | 71% |
| TRAVELERS INS. CO. | 1,817,293,817 | 1,405,793,949 | 77% |
| MUTUAL OF OMAHA INS. CO. | 1,632,415,721 | 1,160,696,109 | 71% |
| METROPOLITAN LIFE INS. CO. | 1,462,106,272 | 982,140,216 | 67% |
| CONTINENTAL ASSUR. CO. | 928,594,628 | 798,698,825 | 86% |
| LINCOLN NATIONAL LIFE INS. | 904,287,298 | 674,843,359 | 75% |
| NEW YORK LIFE INS. CO. | 863,753,678 | 573,572,579 | 66% |
| BANKERS LIFE, IA. | 804,810,831 | 590,624,012 | 73% |
| EQUITABLE LIFE ASSUR. SOCY. | 690,289,990 | 568,498,921 | 82% |
| TRANSAMER. OCCIDENTAL LIFE | 677,325,719 | 589,344,891 | 87% |
| AMER. FAMILY LIFE ASSUR. | 664,070,240 | 270,273,609 | 41% |
| ALLSTATE LIFE INS. | 627,152,318 | 560,695,986 | 89% |
| JOHN HANCOCK MUT. LIFE INS. | 586,864,184 | 459,934,313 | 78% |
| PROVIDENT LIFE & ACCID. CO. | 553,331,705 | 391,705,388 | 71% |
| GUARDIAN LIFE OF AMERICA | 539,946,089 | 417,975,453 | 77% |
| COMBINED INS. CO. OF AMERICA | 536,419,373 | 210,009,276 | 39% |
| GREAT-WEST LIFE ASSUR. | 519,024,000 | 460,441,000 | 89% |
| BANKERS LIFE & CASUALTY | 502,961,365 | 369,080,173 | 73% |
| HARTFORD LIFE & ACCIDENT | 496,053,062 | 407,429,714 | 82% |
| STATE FARM MUTUAL AUTO. | 463,010,357 | 343,630,626 | 74% |
| CROWN LIFE INS. CO. | 462,124,000 | 371,443,000 | 80% |
| CONFEDERATION LIFE INS. CO. | 412,072,000 | 395,960,000 | 96% |
| UNIONMUTUAL STOCK LIFE AM. | 385,481,172 | 263,596,690 | 68% |
| MUTUAL BENEFIT LIFE INS. | 382,154,253 | 288,466,753 | 75% |
| MASSACHUSETTS MUTUAL LIFE | 378,717,942 | 272,825,632 | 72% |
| PILOT LIFE INSURANCE CO. | 343,620,698 | 279,700,231 | 81% |
| LIFE INS. CO OF NO. AMERICAN | 333,735,648 | 238,670,267 | 72% |
| GENERAL AMERICAN LIFE INS. | 318,109,594 | 263,463,324 | 83% |
| FIREMENS FUND EMPLOYERS | 311,313,956 | 223,152,667 | 72% |
| PACIFIC MUTUAL LIFE INS. | 283,812,801 | 204,738,563 | 72% |
| SUN LIFE ASSUR. CO. CANADA | 268,918,000 | 277,262,000 | 103% |
| TIME INSURANCE CO. | 261,727,208 | 168,438,483 | 64% |
| MUTUAL LIFE OF NEW YORK | 252,466,444 | 181,704,425 | 72% |
| STATE MUT. LIFE ASSUR. AMER. | 238,855,974 | 165,507,324 | 69% |
| NATIONWIDE MUTUAL INS. CO. | 238,604,700 | 189,720,645 | 80% |
| PURITAN LIFE INSURANCE CO. | 230,797,160 | 198,653,210 | 86% |
| NEW ENGLAND MUTUAL LIFE | 226,941,447 | 162,553,841 | 72% |
| PAUL REVERE LIFE INS. CO. | 222,300,253 | 125,873,535 | 57% |
| WASHINGTON NATIONAL INSURANCE | 219,780,128 | 135,323,412 | 62% |
| UNITED AMERICAN INS. CO. | 216,629,860 | 94,736,773 | 44% |
| SENTRY LIFE INSURANCE CO. | 208,520,584 | 139,157,803 | 67% |
| NATIONAL HOME LIFE ASSUR. | 208,304,925 | 114,517,368 | 55% |
| COLONIAL PENN. LIFE INS. | 207,183,112 | 174,722,607 | 84% |
| REPUBLIC NATL. LIFE GROUP | 204,256,834 | 166,167,434 | 81% |
| PHYSICIANS MUTUAL INS. CO. | 203,960,369 | 119,032,182 | 58% |



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|---|---|---|---|
| TRAVELERS INS. CO. OF IL. | 182,282,941 | 164,214,285 | 90% |
| GULF LIFE INSURANCE CO. | 178,253,567 | 141,141,900 | 79% |
| LIBERTY MUTUAL INS. CO. | 162,759,741 | 142,889,919 | 88% |
| BENEFIT TRUST LIFE INS. CO. | 162,476,764 | 132,750,729 | 82% |
| EMPLOYERS REINS. CORP. | 159,172,792 | 154,439,837 | 97% |
| COMMERCIAL LIFE INS. CO. | 156,749,883 | 113,834,065 | 73% |
| JOHN ALDEN LIFE INS. CO. | 156,713,543 | 94,532,751 | 60% |
| CANADA LIFE ASSUR. CO. | 156,020,000 | 146,593,000 | 94% |
| N. W. INVESTORS LIFE INS. CO. | 155,993,635 | 101,259,221 | 65% |
| UNION LABOR LIFE | 155,591,654 | 130,467,539 | 84% |
| SAFECO LIFE INSURANCE CO. | 151,067,108 | 95,118,856 | 63% |
| UNITED INS. CO. OF AMERICA | 145,957,279 | 93,403,035 | 64% |
| OHIO STATE LIFE INS. CO. | 145,732,225 | 111,023,471 | 76% |
| HOME LIFE INSURANCE CO. | 142,780,666 | 116,789,755 | 82% |
| PHOENIX MUTUAL LIFE INS. | 135,418,679 | 91,749,936 | 68% |
| AMERICAN COMMUNITY MUTUAL | 134,185,472 | 97,817,736 | 73% |
| MASSACHUSETTS IND. & LIFE | 133,527,315 | 62,411,422 | 47% |
| GOLDEN RULE INSURANCE CO. | 131,094,142 | 73,751,534 | 56% |
| NORTHWESTERN NATL. LIFE | 128,501,105 | 93,806,944 | 73% |
| UNITED STATES LIFE INS. CO. | 128,022,102 | 99,633,207 | 78% |
| ALEXANDER HAMILTON LIFE | 125,979,895 | 91,855,814 | 73% |
| CUDIS INS. SOCIETY INC. | 125,786,925 | 75,904,358 | 60% |
| COLONIAL LIFE & ACCID. INS. | 123,813,806 | 56,552,460 | 46% |
| INDEPENDENT LIFE & ACCID. | 122,698,529 | 62,776,057 | 51% |
| BUSINESS MENS ASSUR. CO. | 118,128,989 | 86,533,160 | 73% |
| PROVIDENT MUTUAL LIFE INS. | 116,514,445 | 84,611,437 | 73% |
| TRAVELERS INDEM. OF RI. | 116,064,999 | 91,124,969 | 79% |
| AMERICAN FAMILY MUTUAL | 114,478,978 | 73,224,831 | 64% |
| CONTINENTAL CASUALTY CO. | 111,327,238 | 82,561,020 | 74% |
| LIBERTY NATIONAL LIFE INS. | 109,390,251 | 58,772,930 | 54% |
| RESERVE LIFE INSURANCE CO. | 107,603,049 | 86,375,818 | 80% |
| LUMBERMENS MUT. CAS. CO. | 104,303,718 | 80,531,375 | 77% |
| COLONIAL LIFE INS. OF AMER. | 104,258,169 | 82,636,364 | 79% |
| UNION MUTUAL LIFE INS. CO. | 101,324,628 | 79,927,962 | 78% |
| STANDARD INSURANCE CO. | 98,981,206 | 85,976,440 | 87% |
| NATIONAL LIFE & ACCIDENT | 95,882,234 | 55,936,457 | 58% |
| PENNSYLVANIA LIFE INS. CO. | 94,923,054 | 48,774,600 | 51% |
| AETNA CAS. & SUR. OF ILL. | 93,562,947 | 100,936,284 | 108% |
| AMERICAN FIDELITY ASSUR. | 92,901,576 | 62,662,038 | 67% |
| DURHAM LIFE INSURANCE CO. | 90,557,309 | 63,319,932 | 70% |
| PRUDENTIAL PROP. & CAS. INS. | 89,963,879 | 87,071,464 | 97% |
| MUTUAL SECURITY LIFE INS. | 87,198,309 | 52,033,072 | 60% |
| FEDERATED MUTUAL INS. CO. | 87,094,100 | 69,523,017 | 80% |
| FIREMANS FUND AMER. LIFE | 82,669,574 | 29,659,755 | 36% |
| UNION CENTRAL LIFE INS. CO. | 81,650,946 | 63,489,602 | 78% |
| GLOBE LIFE & ACCIDENT INS. | 81,304,107 | 43,477,748 | 53% |
| NORTHWESTERN MUTUAL LIFE | 81,136,147 | 38,225,661 | 47% |
| LIFE INS. CO. OF GEORGIA | 80,425,387 | 59,098,800 | 73% |
| PAN-AMERICAN LIFE INS. CO. | 78,937,833 | 60,960,709 | 77% |
| LONE STAR LIFE INS. CO. | 77,726,097 | 49,524,862 | 64% |
| NRG. AMERICA LIFE REASSUR. | 77,604,227 | 19,297,949 | 25% |
| AMERICAN LIFE INS. CO-DE | 76,736,419 | 36,838,050 | 48% |
| COUNTRY LIFE INS. CO. | 75,907,797 | 52,245,056 | 69% |
| AMERICAN REPUBLIC INS. CO. | 73,247,888 | 35,656,749 | 49% |
| ST. PAUL LIFE INS. CO. | 72,151,279 | 51,532,157 | 71% |
| NORTH AMER. LIFE & CAS. CO. | 69,967,287 | 46,441,185 | 66% |



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|---|---|---|---|
| UNION BANKERS INS. CO. | 68,866,507 | 37,703,156 | 55% |
| TEACHERS INS. & ANNUITY AM. | 67,852,989 | 65,672,279 | 97% |
| UNIONMUTUAL STOCK LIFE NY. | 67,694,690 | 49,093,195 | 73% |
| MONTGOMERY WARD LIFE INS. | 64,871,263 | 29,078,027 | 45% |
| CENTRAL LIFE ASSURANCE CO. | 64,847,302 | 45,931,256 | 71% |
| SHELTER LIFE INS. CO. | 64,574,668 | 43,829,193 | 68% |
| PROTECTIVE LIFE INS. CO. | 63,605,474 | 49,013,300 | 77% |
| LIFE INVESTORS INS/AMER | 63,400,124 | 38,500,144 | 61% |
| AMERICAN HERITAGE LIFE | 62,738,995 | 45,725,069 | 73% |
| AMERICAN UNITED LIFE INS. | 61,857,670 | 46,543,168 | 75% |
| SWISS-AM REASSURANCE CO. | 61,455,759 | 76,261,865 | 124% |
| HORACE MANN LIFE INS. CO. | 61,268,187 | 45,985,519 | 75% |
| MONARCH LIFE INS. CO. | 60,964,578 | 38,946,556 | 64% |
| AMERICAN NATIONAL INSURANCE | 60,156,922 | 42,785,364 | 71% |
| GROUP LIFE & HEALTH INS. | 60,085,854 | 58,524,396 | 97% |
| LIBERTY LIFE INSURANCE CO. | 55,720,630 | 41,911,417 | 75% |
| LIFE INS. CO. OF VIRGINIA | 55,596,987 | 44,354,473 | 80% |
| AID ASSN. FOR LUTHERANS-WI | 55,074,403 | 36,134,188 | 66% |
| FEDERAL HOME LIFE INS. CO. | 55,018,110 | 33,900,447 | 62% |
| CENTRAL STATES HLTH & LIFE | 54,897,581 | 27,185,984 | 50% |
| CUNA MUTUAL INS. SOCIETY | 54,560,029 | 38,219,547 | 70% |
| GULF LIFE GROUP INS. CO. | 54,235,663 | 49,617,889 | 91% |
| RELIANCE STANDARD LIFE | 52,742,095 | 41,683,363 | 79% |
| SWISS REINS. CO. | 52,597,136 | 50,013,962 | 95% |
| AETNA LIFE INS. CO. OF ILL. | 52,042,203 | 47,459,270 | 91% |
| CENTRAL RESERVE LIFE-NA | 51,434,767 | 29,466,332 | 57% |
| MINNESOTA MUTUAL LIFE INS. | 51,329,158 | 32,915,523 | 64% |
| TRAVERLERS INDEMNITY | 50,914,607 | 9,469,615 | 19% |
| CALIFORNIA WESTERN STATES | 50,859,051 | 65,841,872 | 129% |
| EQUITABLE CAS. INS. CO. | 50,565,091 | 57,542,085 | 114% |
| AMERICAN CHAMBERS LIFE | 50,413,893 | 33,948,184 | 67% |
| CERTIFIED LIFE INS. CO-CA | 49,202,770 | 25,921,746 | 53% |
| J. C. PENNEY LIFE INS. CO. | 49,200,141 | 20,092,898 | 41% |
| AIG LIFE INSURANCE CO. | 49,113,954 | 27,413,047 | 56% |
| BCS LIFE INSURANCE CO. | 49,041,092 | 42,549,609 | 87% |
| AMERICAN BANKERS LIFE FLA | 48,867,410 | 22,390,935 | 46% |
| STANDARD LIFE & ACCID. INS. | 48,678,888 | 31,206,258 | 64% |
| NATIONAL CASUALTY CO. | 48,341,698 | 30,067,124 | 62% |
| GREAT SOUTHERN LIFE INS. | 47,075,608 | 36,373,766 | 77% |
| BLC INSURANCE CO. | 45,028,360 | 29,514,373 | 66% |
| WESTERN LIFE INSURANCE CO. | 44,494,014 | 31,085,338 | 70% |
| PHILADELPHIA AMERICAN LIFE | 44,439,114 | 39,385,768 | 89% |
| ASSOCIATION LIFE INSURANCE CO. | 44,302,851 | 29,639,255 | 67% |
| WOODMEN ACCIDENT & LIFE | 44,274,070 | 32,424,217 | 73% |
| TRANSPORT LIFE INS. CO. | 44,188,532 | 15,890,150 | 36% |
| VULCAN LIFE INSURANCE CO. | 44,137,209 | 35,235,210 | 80% |
| GUARANTEE TRUST LIFE INS. | 44,128,284 | 30,631,133 | 69% |
| PAUL REVERE PROT. LIFE | 44,111,986 | 13,601,276 | 31% |
| METROPOLITAN PROP. & LIAB. | 43,500,430 | 89,262,889 | 205% |
| INTER-OCEAN INS. CO. | 43,296,579 | 24,768,062 | 57% |
| DOMINION LIFE ASSURANCE | 43,092,000 | 39,938,000 | 93% |
| BANKERS LIFE OF NEB. | 43,004,472 | 29,321,955 | 68% |
| AMERICAN MOTORISTS INS. CO. | 42,887,284 | 32,553,447 | 76% |
| PROVIDENT ALLIANCE LIFE | 42,863,764 | 23,647,906 | 55% |
| PRUDENTIAL REINS. CO. | 42,336,998 | 3,591,388 | 8% |
| CONTINENTAL LIFE & ACCIDENT | 41,784,132 | 33,454,585 | 80% |



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|---|---|---|---|
| NORTH AMERICAN REINS. CO. | 41,530,415 | 40,920,511 | [illegible] |
| NATIONAL BENEFIT LIFE | 41,242,553 | 25,535,068 | [illegible] |
| RURAL SECURITY LIFE INS. | 41,104,720 | 32,431,627 | 79% |
| COLOGNE LIFE REINS. CO. | 40,900,159 | 30,456,941 | 74% |
| LYNDON INS CO. | 40,718,000 | 31,848,000 | 78% |
| NATIONWIDE MUTUAL FIRE | 39,299,598 | 31,248,106 | 80% |
| INA LIFE INSURANCE OF NY | 39,295,522 | 29,110,986 | 74% |
| MID-CONTINENT CASUALTY CO. | 38,991,115 | 16,105,106 | 41% |
| PHF LIFE INSURANCE CO. | 38,671,405 | 25,133,695 | 65% |
| MUTUAL SERVICE LIFE INS. | 38,444,527 | 28,926,901 | 75% |
| GENERAL REASSURANCE CORP. | 38,057,515 | 21,919,150 | 58% |
| RELIANCE INSURANCE CO. | 37,963,344 | 30,455,945 | 80% |
| PYRAMID LIFE INSURANCE CO. | 37,177,325 | 23,414,540 | 63% |
| EDUCATORS MUTUAL LIFE INS. | 37,130,639 | 30,118,401 | [illegible] |
| BANKERS UNITED LIFE ASSUR. | 36,275,774 | 21,426,020 | |
| MUTUAL PROTECTIVE INS. CO. | 35,295,954 | 15,575,207 | |
| ILLINOIS MUTUAL LIFE & CAS. | 35,254,433 | 25,366,777 | [illegible] |
| CAL-FARM LIFE | 35,131,270 | 30,536,697 | 87% |
| AMERICAN GENERAL LIFE TX. | 34,774,213 | 31,920,211 | 92% |
| LYNDON INSURANCE CO. | 34,467,324 | 12,239,777 | 36% |
| EXECUTIVE FUND LIFE INS. | 34,328,508 | 13,842,449 | 40% |
| LIFE & CASUALTY OF TN. | 34,318,430 | 21,528,455 | 63% |
| AMERICAN STATES INS. CO. | 33,485,678 | 21,005,566 | 63% |
| PROVIDENT LIFE & CAS. INS. | 33,118,357 | 21,284,306 | 64% |
| GEORGIA INTERNATL LIFE CO. | 32,847,626 | 24,911,290 | 76% |
| CONNECTICUT MUTUAL LIFE | 32,781,309 | 18,521,743 | 57% |
| RESERVE NATIONAL INS. CO. | 32,665,795 | 15,864,809 | 49% |
| OXFORD LIFE INS. CO. | 32,097,368 | 24,766,362 | 77% |
| SOUTHLAND LIFE INS. CO. | 31,816,282 | 20,765,156 | 65% |
| AMERICAN HARDWARE MUTUAL | 31,736,486 | 26,752,199 | 84% |
| NORTHBROOK LIFE INS. | 31,673,840 | 27,939,332 | 88% |
| PIONEER LIFE INS. CO. OF IL. | 31,520,933 | 16,936,461 | 54% |
| GREAT REPUBLIC LIFE OF CA. | 31,326,108 | 21,386,839 | 68% |
| BANKERS MULTIPLE LINE INS. | 30,854,283 | 18,068,252 | 59% |
| AMERICAN INTERNATL. LIFE | 30,378,579 | 22,829,831 | 75% |
| FARMERS NEW WORLD LIFE CO. | 30,348,638 | 24,920,444 | 82% |
| CALIFORNIA LIFE INS. CO. | 29,881,401 | 26,337,981 | 88% |
| AETNA LIFE INS. & ANNUITY | 29,794,025 | 16,821,256 | 56% |
| COMBINED LIFE INS. CO-NY | 29,717,535 | 11,826,089 | 40% |
| JOHN DEERE INS. CO. | 29,681,215 | 26,629,747 | 90% |
| AMERICAN LIFE & CAS. INS. | 29,637,314 | 18,222,343 | 61% |
| AMALGAMATED LABOR LIFE | 29,625,934 | 28,098,021 | 95% |
| NATIONAL FIRE INS. | 29,129,798 | 21,602,853 | 74% |
| GREAT AMERICAN RESERVE CO. | 29,106,243 | 22,383,348 | 77% |
| MENNONITE MUTUAL AID ASSN. | 28,828,031 | 23,393,567 | 81% |
| ZURICH INS. CO. | 28,799,180 | 17,295,700 | 60% |
| MERIT LIFE INS. CO. | 28,521,550 | 13,178,947 | 46% |
| CUMBERLAND LIFE INS. TENN. | 27,900,013 | 10,333,959 | 37% |
| COLUMBUS MUTUAL LIFE INS. | 27,474,581 | 22,358,096 | 81% |
| HOME SECURITY LIFE INS-NC | 27,319,382 | 21,700,778 | 79% |
| GUARANTEE MUTUAL LIFE CO. | 27,248,471 | 21,875,557 | 80% |
| BENEFICIAL STANDARD LIFE | 27,005,734 | 14,766,074 | 55% |
| CENTENNIAL LIFE INS. CO. | 26,190,298 | 16,944,678 | 65% |
| GLOBE LIFE INS. CO. | 26,189,900 | 6,070,707 | 23% |
| AMERICAN INCOME LIFE INS. | 25,773,413 | 13,764,297 | 53% |
| NATIONAL STATES INS. CO. | 25,626,852 | 11,558,308 | 45% |



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|---|---|---|---|
| AMERICAN STATES LIFE INS. | 25,559,161 | 23,423,198 | 92% |
| CALIFORNIA PHYSICIANS INS. | 24,956,034 | 19,172,281 | 77% |
| WESTERN-SOUTHERN LIFE INS. | 24,858,136 | 18,073,632 | 73% |
| CREDIT LIFE INSURANCE CO. | 24,762,099 | 10,816,892 | 44% |
| WORLD INSURANCE CO. | 24,734,991 | 14,883,396 | 60% |
| MANUFACTURERS LIFE INS. CO. | 24,733,000 | 22,395,000 | 91% |
| MONUMENTAL LIFE INS. | 24,650,735 | 14,201,221 | 58% |
| AMERICAN HLTH. & LIFE INS. | 24,341,822 | 18,070,241 | 74% |
| EQUITABLE LIFE & CAS. INS. | 24,274,469 | 12,356,093 | 51% |
| AMERICAN SECURITY LIFE | 24,242,287 | 18,986,185 | 78% |
| CELTIC LIFE INS.-R I | 23,880,306 | 15,763,907 | 66% |
| NATIONAL LIBERTY LIFE INS. | 23,808,583 | 12,975,015 | 54% |
| CAMPANION LIFE INS. - NY | 23,523,983 | 16,618,672 | 71% |
| LUMBERMENS LIFE INS. CO. | 22,981,394 | 16,065,654 | 70% |
| CONTINENTAL AMER. LIFE INS. | 22,796,027 | 10,730,870 | 47% |
| ALL AMERICAN LIFE | 22,761,169 | 14,014,307 | 62% |
| NATIONAL LIFE INS. CO., VT | 22,534,475 | 13,593,432 | 60% |
| PAULA INS. CO. | 22,422,321 | 18,706,478 | 83% |
| UNITED FARM BUR. FAM. LIFE | 22,264,186 | 16,951,235 | 76% |
| BLUE ALLIANCE MUTUAL INS. | 22,262,185 | 12,446,175 | 56% |
| AMERICAN ROAD INS. | 22,191,484 | 12,851,344 | 58% |
| IDS LIFE INS. CO. | 22,156,995 | 12,386,444 | 56% |
| UNITED WISCONSIN INS. CO. | 21,573,000 | 16,788,819 | 78% |
| COMMONWEALTH LIFE INS. - KY | 21,412,722 | 14,214,250 | 66% |
| MACCABEES MUTUAL LIFE | 20,658,823 | 12,976,304 | 63% |
| UNITED LIFE & ACCIDENT | 20,578,024 | 12,901,878 | 63% |
| SECURITY OF AMER. LIFE INS. | 20,415,038 | 12,336,451 | 60% |
| GEORGIA CAS. & SUR. CO. | 20,299,682 | 8,682,218 | 43% |
| FARMLAND LIFE INS. CO. | 20,165,347 | 14,393,236 | 71% |
| MICHIGAN LIFE INS. CO. | 19,990,108 | 17,548,777 | 88% |
| APPLACHIAN NATL. LIFE INS. | 19,696,617 | 13,488,030 | 68% |
| GEORGE WASHINGTON LIFE CO. | 19,591,951 | 9,989,373 | 51% |
| INTERCONTINENTAL LIFE - PR | 19,526,098 | 14,499,958 | 74% |
| ORANGE STATE LIFE & HLTH. | 19,275,443 | 12,691,089 | 66% |
| PEKIN LIFE INS. CO. | 19,[illegible]35,395 | 11,897,802 | 62% |
| LAMAR LIFE INS. CO. | 19,102,487 | 14,333,128 | 75% |
| NORTH CENTRAL LIFE INS. CO. | 19,083,200 | 6,089,407 | 32% |
| COMMERCIAL BANKERS LIFE | 19,058,916 | 13,452,904 | 71% |
| EQUITY NATIONAL LIFE INS. | 19,029,890 | 7,803,195 | 41% |
| AIU INS. CO. | 18,937,872 | 7,660,618 | 40% |
| BOSTON MUTUAL LIFE | 18,886,679 | 11,555,998 | 61% |
| PACIFIC HERITAGE ASSUR. CO. | 18,877,546 | 12,502,620 | 66% |
| LIBERTY LIFE ASSUR./BOSTON | 18,821,353 | 16,579,960 | 88% |
| MONUMENTAL GENL. INS. CO. | 18,709,626 | 10,069,065 | 54% |
| MASSACHUSETTS CAS. INS. | 18,398,816 | 1,859,129 | 10% |
| OLD AMERICAN INS. CO. | 18,300,907 | 8,546,542 | 47% |
| UNITED FIDELITY LIFE INS. | 18,225,785 | 13,422,878 | 74% |
| LIBERTY MUT. FIRE INS. CO. | 18,084,417 | 15,876,650 | 88% |
| EAGLE LIFE INS. CO. | 18,059,696 | 7,196,819 | 40% |
| FIRST HORIZON INS. | 18,036,741 | 8,589,223 | 48% |
| KENTUCKY CENTRAL LIFE | 17,827,141 | 11,027,365 | 62% |
| CONTINENTAL GENERAL INS. | 17,756,872 | 7,911,476 | 45% |
| LUTHERAN BROTHERHOOD | 17,640,090 | 8,356,[illegible]33 | 47% |
| BANNER LIFE INS. | 17,300,135 | 6,374,875 | 37% |
| CENTRAL NATL. INS. CO. - OMAHA | 17,134,868 | 2,129,270 | 12% |
| DEPENDABLE LIFE INS. CO. - FL | 17,133,126 | 13,241,352 | 77% |



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|---|---|---|---|
| FIRST DELAWARE LIFE | 17,060,716 | 14,425,782 | 85% |
| AMERICAN GENERAL LIFE DE. | 16,926,090 | 10,879,695 | 64% |
| HARBOR INSURANCE CO. | 16,633,096 | 11,137,648 | 67% |
| NATIONAL FARMERS UNION | 16,622,861 | 12,653,016 | 76% |
| UNION NATL. LIFE INS. OF LA | 16,621,736 | 5,740,988 | 35% |
| AMERICAN SERVICE LIFE - TX | 16,385,994 | 8,213,300 | 50% |
| UNION LIFE INS. CO. | 16,348,614 | 13,324,899 | 82% |
| FOREMOST LIFE INS. | 15,925,791 | 10,243,670 | 64% |
| SMA LIFE ASSUR. CO. | 15,746,765 | 10,102,861 | 64% |
| COOPERANTS MUT. LIFE SOCY. | 15,722,000 | 11,788,000 | 75% |
| CONNECTICUT NATIONAL | 15,591,951 | 10,336,217 | 66% |
| NATIONAL TRAVELERS LIFE | 15,497,656 | 11,426,856 | 74% |
| CONSUMER BENEFIT LIFE | 15,484,934 | 11,141,742 | 72% |
| SENTRY INS. CO. A. MUTUAL | 14,915,804 | 12,687,068 | 85% |
| INTERCONTINENTAL LIFE INS. | 14,910,224 | 8,002,686 | 54% |
| INTRAMERICA LIFE INS. CO. | 14,755,061 | 13,819,958 | 94% |
| WINTERTHUR SWISS INS. CO. | 14,716,036 | 9,267,010 | 63% |
| HOME INS. CO. | 14,684,608 | 9,408,031 | 64% |
| BEST LIFE ASSUR. CO. CA | 14,419,430 | 10,111,648 | 70% |
| LIFE INS. CO. OF SOUTHWEST | 14,341,498 | 10,634,593 | 74% |
| CENTRAL STATES INDEMNITY | 14,198,432 | 3,922,616 | 28% |
| PENINSULAR LIFE INS. CO. | 14,054,904 | 5,590,015 | 40% |
| PROVIDENT INDEMNITY LIFE | 13,853,752 | 8,718,911 | 63% |
| NATL. HOME LIFE ASSUR. - NY | 13,726,241 | 7,346,332 | 54% |
| NORTH AMER. CO/L&H INS. | 13,685,106 | 18,749,564 | 137% |
| LOYAL AMERICAN LIFE INS. | 13,541,179 | 5,089,490 | 38% |
| WORLD SERVICE OF COLORADO | 13,511,467 | 13,670,339 | 101% |
| NORTH CAROLINA MUT. LIFE | 13,391,539 | 10,669,785 | 80% |
| SAVERS LIFE INS. OF AMER. | 13,332,770 | 8,712,080 | 65% |
| FIDELITY SECURITY LIFE CO. | 13,153,025 | 3,924,131 | 30% |
| MUTUAL SAVINGS LIFE INS. | 12,717,679 | 5,408,379 | 43% |
| FIRST NATIONAL LIFE - AL | 12,595,025 | 8,919,333 | 71% |
| AMERICAN MUTUAL LIAB. INS. | 12,568,497 | 12,277,928 | 98% |
| MINISTERS LIFE A MUTUAL | 12,465,911 | 10,941,580 | 88% |
| BERKSHIRE LIFE INS. CO. | 12,400,729 | 3,255,781 | 26% |
| UNITED EQUITABLE INS. | 12,198,853 | 4,664,134 | 38% |
| PROVIDENT GENERAL INS. CO. | 12,186,135 | 15,734,670 | 129% |
| NEW ENGLAND GEN. LIFE INS. | 12,108,928 | 13,961,242 | 115% |
| HERITAGE LIFE INS. CO. | 12,052,051 | 4,376,167 | 36% |
| CONTINENTAL LIFE INS. TX | 12,023,789 | 4,431,757 | 37% |
| AMERICAN CASUALTY CO. | 11,994,624 | 8,897,292 | 74% |
| AMERICAN INTEGRITY INS. CO. | 11,954,742 | 3,548,255 | 30% |
| LIFE ASSUR. CO. OF PA. | 11,887,297 | 1,180,662 | 10% |
| AMERICAN STANDARD L & A | 11,807,093 | 6,581,537 | 56% |
| AMERICAN HOME ASSUR. CO. | 11,654,764 | 5,670,763 | 49% |
| OLD SOUTHERN LIFE INS. CO. | 11,640,231 | 6,135,845 | 53% |
| INS. CO. OF NORTH AMERICA | 11,608,492 | 5,715,892 | 49% |
| SIERRA GENERAL LIFE INS. | 11,554,583 | 10,683,251 | 92% |
| VETERANS LIFE INS. CO. | 11,527,676 | 6,353,368 | 55% |
| SECURITY MUTUAL LIFE, NE | 11,482,174 | 10,545,745 | 92% |
| INVESTORS HERITAGE LIFE | 11,347,089 | 7,787,039 | 69% |
| WABASH LIFE INS. CO. | 11,316,909 | 6,626,654 | 59% |
| ZALE LIFE INS. CO. | 11,267,808 | 6,384,109 | 57% |
| AMERICAN BANKERS INS. CO. | 11,236,691 | 6,995,852 | 62% |
| WORLD LIFE & HEALTH INS. | 11,243,961 | 5,108,198 | 45% |
| FIRST CONTINENTAL L & A INS. | 11,199,888 | 5,858,328 | 52% |



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|---|---|---|---|
| IMPERIAL CAS. & INDEMN. CO. | 11,104,674 | 4,548,758 | 41% |
| PEERLESS INS. CO. | 10,911,256 | 8,927,586 | 82% |
| AMERICAN INDEPENDENT INS. | 10,876,697 | 5,949,859 | 55% |
| UNITED FOUNDERS LIFE - OK | 10,838,264 | 6,884,699 | 64% |
| SPRINGFIELD LIFE INS. | 10,766,254 | 7,151,245 | 66% |
| SECURITY MUTUAL LIFE NY | 10,721,919 | 7,971,778 | 74% |
| AMERICAN WAY LIFE INS. | 10,720,882 | 892,677 | 8% |
| MIDLAND MUTUAL LIFE INS. | 10,634,469 | 3,358,137 | 32% |
| NATIONAL SAVINGS LIFE - TN | 10,598,127 | 7,431,457 | 70% |
| FORUM INSURANCE CO. | 10,501,509 | 5,912,237 | 56% |
| JMIC LIFE INS. CO. | 10,478,972 | 1,988,264 | 19% |
| MIC LIFE INS. CORP. | 10,409,129 | 5,901,638 | 57% |
| GERLING GLOBAL REINS. CORP. | 10,359,204 | 8,652,105 | 84% |
| ACADEMY LIFE INS. CO. | 10,318,354 | 6,780,773 | 66% |
| AMER. MANUFACTURERS MUT. | 10,296,138 | 7,959,729 | 77% |
| RURAL MUTUAL INS. | 10,102,229 | 8,244,528 | 82% |
| ARCADIA INSURANCE CO. | 10,089,785 | 4,823,666 | 48% |



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APPENDIX E-2

PREMIUMS--CLAIMS--LOSS RATIO
RANKING BY LOSS RATIO (DESCENDING)

| COMPANY | PREMIUMS EARNED LESS DIVIDENDS (DOLLARS) | CLAIMS INCURRED (DOLLARS) | LOSS RATIO |
|---|---|---|---|
| METROPOLITAN PROP. & LIAB. | 43,500,430 | 89,262,889 | 205% |
| CONNECTICUT GENERAL LIFE | 1,996,942,214 | 2,842,863,656 | 142% |
| NORTH AMER. CO/L&H INS. | 13,685,106 | 18,749,564 | 137% |
| CALIFORNIA WESTERN STATES | 50,859,051 | 65,841,872 | 129% |
| PROVIDENT GENERAL INS. CO. | 12,186,135 | 15,734,670 | 129% |
| SWISS-AM REASSURANCE CO. | 61,455,759 | 76,261,865 | 124% |
| NEW ENGLAND GEN. LIFE INS. | 12,108,928 | 13,961,242 | 115% |
| EQUITABLE CAS. INS. CO. | 50,565,091 | 57,542,085 | 114% |
| AETNA CAS. & SUR. OF ILL. | 93,562,947 | 100,936,284 | 108% |
| SUN LIFE ASSUR. CO. CANADA | 268,918,000 | 277,262,000 | 103% |
| WORLD SERVICE OF COLORADO | 13,511,467 | 13,670,339 | 101% |
| NORTH AMERICAN REINS. CO. | 41,530,415 | 40,920,511 | 99% |
| AMERICAN MUTUAL LIAB. INS. | 12,568,497 | 12,277,928 | 98% |
| GROUP LIFE & HEALTH INS. | 60,085,854 | 58,524,396 | 97% |
| EMPLOYERS REINS. CORP. | 159,173,792 | 154,439,837 | 97% |
| TEACHERS INS. & ANNUITY AM. | 67,852,989 | 65,672,279 | 97% |
| PRUDENTIAL PROP. & CAS. INS. | 89,963,879 | 87,071,464 | 97% |
| JOHN DEERE INS. CO. | 29,681,215 | 28,629,747 | 96% |
| CONFEDERATION LIFE INS. CO. | 412,072,000 | 395,960,000 | 96% |
| SWISS REINS. CO. | 52,597,136 | 50,013,962 | 95% |
| AMALGAMATED LABOR LIFE | 29,625,934 | 28,098,021 | 95% |
| CANADA LIFE ASSUR. CO. | 156,020,000 | 146,593,000 | 94% |
| INTRAMERICA LIFE INS. CO. | 14,755,061 | 13,819,958 | 94% |
| DOMINION LIFE ASSURANCE | 43,092,000 | 39,938,000 | 93% |
| SIERRA GENERAL LIFE INS. | 11,554,583 | 10,683,251 | 92% |
| SECURITY MUTUAL LIFE, NE | 11,482,174 | 10,545,745 | 92% |
| AMERICAN GENERAL LIFE TX. | 34,774,213 | 31,920,211 | 92% |
| AMERICAN STATES LIFE INS. | 25,559,161 | 23,423,198 | 92% |
| GULF LIFE GROUP INS. CO. | 54,235,663 | 49,617,889 | 91% |
| AETNA LIFE INS. CO. OF ILL. | 52,042,203 | 47,459,270 | 91% |
| MANUFACTURERS LIFE INS. CO. | 24,733,000 | 22,395,000 | 91% |
| TRAVELERS INS. CO. OF IL. | 182,282,941 | 164,214,205 | 90% |
| ALLSTATE LIFE INS. | 627,152,318 | 560,695,986 | 89% |
| GREAT-WEST LIFE ASSUR. | 519,024,000 | 460,441,000 | 89% |
| PHILADELPHIA AMERICAN LIFE | 44,439,114 | 39,385,768 | 89% |
| NORTHBROOK LIFE INS. | 31,673,840 | 27,939,332 | 88% |
| CALIFORNIA LIFE INS. CO. | 29,881,401 | 26,337,981 | 88% |
| LIBERTY LIFE ASSUR./BOSTON | 18,821,353 | 16,579,960 | 88% |
| LIBERTY MUTUAL INS. CO. | 162,759,741 | 142,889,919 | 88% |
| LIBERTY MUT. FIRE INS. CO. | 18,084,417 | 15,876,658 | 88% |
| MICHIGAN LIFE INS. CO. | 19,990,108 | 17,548,777 | 88% |
| MINISTERS LIFE A MUTUAL | 12,465,911 | 10,941,580 | 88% |
| TRANSAMER. OCCIDENTALLIFE | 677,325,719 | 589,344,891 | 87% |
| CAL-FARM LIFE | 35,131,270 | 30,536,697 | 87% |
| STANDARD INSURANCE CO. | 98,981,206 | 85,976,440 | 87% |
| BCS LIFE INSURANCE CO. | 49,041,092 | 42,549,609 | 87% |
| PURITAN LIFE INSURANCE CO. | 230,797,168 | 198,653,210 | 86% |



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| CONTINENTAL ASSUR. CO. | 928,594,628 | 798,698,825 | 86% |
| SENTRY INS. CO. A. MUTUAL | 14,915,804 | 12,687,068 | 85% |
| FIRST DELAWARE LIFE | 17,060,716 | 14,425,722 | 85% |
| COLONIAL PENN. LIFE INS. | 207,183,112 | 174,722,607 | 84% |
| AMERICAN HARDWARE MUTUAL | 31,736,486 | 26,752,199 | 84% |
| UNION LABOR LIFE | 155,591,654 | 130,467,539 | 84% |
| GERLING GLOBAL REINS. CORP. | 10,359,204 | 8,652,105 | 84% |
| PAULA INS. CO. | 22,422,321 | 18,706,478 | 83% |
| GENERAL AMERICAN LIFE INS. | 318,109,594 | 263,463,324 | 83% |
| EQUITABLE LIFE ASSUR. SOCY. | 690,289,990 | 568,498,921 | 82% |
| HARTFORD LIFE & ACCIDENT | 496,053,062 | 407,429,714 | 82% |
| FARMERS NEW WORLD LIFE CO. | 30,348,638 | 24,920,444 | 82% |
| PEERLESS INS. CO. | 10,911,258 | 8,927,586 | 82% |
| HOME LIFE INSURANCE CO. | 142,780,666 | 116,789,755 | 82% |
| BENEFIT TRUST LIFE INS. CO. | 162,476,764 | 132,750,729 | 82% |
| RURAL MUTUAL INS. | 10,102,229 | 8,244,528 | 82% |
| UNION LIFE INS. CO. | 16,348,614 | 13,324,899 | 82% |
| PILOT LIFE INSURANCE CO. | 343,620,698 | 279,700,231 | 81% |
| COLUMBUS MUTUAL LIFE INS. | 27,474,581 | 22,358,096 | 81% |
| REPUBLIC NATL. LIFE GROUP | 204,256,834 | 166,167,434 | 81% |
| MENNONITE MUTUAL AID ASSN. | 28,828,031 | 23,393,567 | 81% |
| EDUCATORS MUTUAL LIFE INS. | 37,130,639 | 30,118,401 | 81% |
| CROWN LIFE INS. CO. | 462,124,000 | 371,443,000 | 80% |
| GUARANTEE MUTUAL LIFE CO. | 27,248,471 | 21,875,557 | 80% |
| RESERVE LIFE INSURANCE CO. | 107,603,049 | 86,375,818 | 80% |
| RELIANCE INSURANCE CO. | 37,963,344 | 30,455,945 | 80% |
| CONTINENTAL LIFE & ACCIDENT | 41,784,132 | 33,454,585 | 80% |
| VULCAN LIFE INSURANCE CO. | 44,137,209 | 35,235,210 | 80% |
| FEDERATED MUTUAL INS. CO. | 87,094,100 | 69,523,017 | 80% |
| LIFE INS. CO. OF VIRGINIA | 55,596,987 | 44,354,473 | 80% |
| NORTH CAROLINA MUT. LIFE | 13,391,539 | 10,669,725 | 80% |
| NATIONWIDE MUTUAL INS. CO. | 238,604,700 | 189,720,645 | 80% |
| NATIONWIDE MUTUAL FIRE | 39,299,598 | 31,248,106 | 80% |
| HOME SECURITY LIFE INS-NC | 27,319,382 | 21,700,778 | 79% |
| COLONIAL LIFE INS. OF AMER. | 104,258,169 | 82,636,364 | 79% |
| GULF LIFE INSURANCE CO. | 179,253,567 | 141,141,960 | 79% |
| RELIANCE STANDARD LIFE | 52,742,095 | 41,683,363 | 79% |
| RURAL SECURITY LIFE INS. | 41,104,722 | 32,431,627 | 79% |
| UNION MUTUAL LIFE INS. CO. | 101,324,628 | 79,927,962 | 79% |
| TRAVELERS INDEM. OF RI. | 116,064,999 | 91,124,969 | 79% |
| JOHN HANCOCK MUT. LIFE INS. | 586,864,184 | 459,934,313 | 78% |
| AMERICAN SECURITY LIFE | 24,242,287 | 18,986,185 | 78% |
| LYNDON INS CO. | 40,718,000 | 31,848,000 | 78% |
| UNITED STATES LIFE INS. CO. | 128,022,102 | 99,633,207 | 78% |
| UNITED WISCONSIN INS. CO. | 21,573,000 | 16,788,819 | 78% |
| UNION CENTRAL LIFE INS. CO. | 81,650,946 | 63,489,602 | 78% |
| PRUDENTIAL INS. OF AMER. | 2,702,628,771 | 2,099,725,986 | 78% |
| GUARDIAN LIFE OF AMERIC | 539,946,089 | 417,975,453 | 77% |
| TRAVELERS INS. CO. | 1,817,293,817 | 1,405,793,949 | 77% |
| AMER. MANUFACTURERS MUT. | 10,296,138 | 7,959,729 | 77% |
| DEPENDABLE LIFE INS. CO. - FL. | 17,133,126 | 13,241,052 | 77% |
| GREAT SOUTHERN LIFE INS. | 47,875,608 | 36,373,766 | 77% |
| PAN-AMERICAN LIFE INS. CO. | 78,937,833 | 60,960,709 | 77% |
| LUMBERMENS MUT. CAS. CO. | 104,303,718 | 80,531,375 | 77% |
| OXFORD LIFE INS. CO. | 32,097,368 | 24,766,362 | 77% |
| PROTECTIVE LIFE INS. CO. | 63,605,474 | 49,013,300 | 77% |



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| GREAT AMERICAN RESERVE CO. | 29,106,243 | 22,383,348 | 77% |
| CALIFORNIA PHYSICIANS INS. | 24,956,034 | 19,172,281 | 77% |
| OHIO STATE LIFE INS. CO. | 145,733,225 | 111,023,471 | 76% |
| UNITED FARM BUR. FAM. LIFE | 22,264,186 | 16,951,235 | 76% |
| NATIONAL FARMERS UNION | 16,622,861 | 12,653,016 | 76% |
| AMERICAN MOTORISTS INS. CO. | 42,887,284 | 32,553,447 | 76% |
| GEORGIA INTERNATL LIFE CO. | 32,847,626 | 24,911,290 | 76% |
| MUTUAL BENEFIT LIFE INS. | 382,154,253 | 288,466,753 | 75% |
| MUTUAL SERVICE LIFE INS. | 38,444,527 | 28,926,901 | 75% |
| AMERICAN UNITED LIFE INS. | 61,857,570 | 46,543,168 | 75% |
| LIBERTY LIFE INSURANCE CO. | 55,720,630 | 41,911,417 | 75% |
| AMERICAN INTERNATL. LIFE | 30,378,579 | 22,829,831 | 75% |
| HORACE MANN LIFE INS. CO. | 61,268,187 | 45,985,5 9 | 75% |
| LAMAR LIFE INS. CO. | 19,102,487 | 14,333,128 | 75% |
| COOPERANTS MUT. LIFE SOCY. | 15,722,000 | 11,788,000 | 75% |
| LINCOLN NATIONAL LIFE INS. | 904,287,298 | 674,843,359 | 75% |
| COLOGNE LIFE REINS. CO. | 40,900,159 | 30,456,941 | 74% |
| SECURITY MUTUAL LIFE NY | 10,721,919 | 7,971,778 | 74% |
| INTERCONTINENTAL LIFE - PR | 19,526,098 | 14,499,958 | 74% |
| AMERICAN HLTH. & LIFE INS. | 24,341,822 | 18,070,241 | 74% |
| STATE FARM MUTUAL AUTO. | 463,010,357 | 343,630,626 | 74% |
| NATIONAL FIRE INS. | 29,129,798 | 2 ,602,853 | 74% |
| CONTINENTAL CASUALTY CO. | 111,327,238 | 82,561,020 | 74% |
| AMERICAN CASUALTY CO. | 11,994,624 | 8,895,292 | 74% |
| LIFE INS. CO. OF SOUTHWEST | 14,341,498 | 10,634,593 | 74% |
| INA LIFE INSURANCE OF NY | 39,295,522 | 29,110,986 | 74% |
| NATIONAL TRAVELERS LIFE | 15,497,656 | 11,426,856 | 74% |
| UNITED FIDELITY LIFE INS. | 18,225,785 | 13,422,878 | 74% |
| LIFE INS. CO. OF GEORGIA | 80,425,387 | 59,098,800 | 73% |
| BANKERS LIFE, IA. | 804,810,831 | 590,624,012 | 73% |
| BANKERS LIFE & CASUALTY | 502,961,365 | 369,080,173 | 73% |
| BUSINESS MENS ASSUR. CO. | 118,128,989 | 86,533,160 | 73% |
| WOODMEN ACCIDENT & LIFE | 44,274,070 | 32,424,217 | 73% |
| NORTHWESTERN NATL. LIFE | 128,501,105 | 93,806,944 | 73% |
| ALEXANDER HAMILTON LIFE | 125,979,895 | 91,855,814 | 73% |
| AMERICAN COMMUNITY MUTUAL | 134,185,472 | 97,817,736 | 73% |
| AMERICAN HERITAGE LIFE | 62,738,995 | 45,725,069 | 73% |
| UNIONMUTUAL STOCK LIFE NY. | 67,694,690 | 49,293,195 | 73% |
| WESTERN-SOUTHERN LIFE INS. | 24,858,136 | 18,073,632 | 73% |
| COMMERCIAL LIFE INS. CO. | 156,749,883 | 113,834,065 | 73% |
| PROVIDENT MUTUAL LIFE INS. | 116,514,445 | 84,611,437 | 73% |
| PACIFIC MUTUAL LIFE INS. | 283,812,801 | 204,738,563 | 72% |
| MASSACHUSETTS MUTUAL LIFE | 378,717,942 | 272,825,632 | 72% |
| MUTUAL LIFE OF NEW YORK | 252,466,444 | 181,704,425 | 72% |
| ILLINOIS MUTUAL LIFE & CAS. | 35,254,433 | 25,366,777 | 72% |
| CONSUMER BENEFIT LIFE | 15,484,934 | 11,141,742 | 72% |
| FIREMENS FUND EMPLOYERS | 311,313,956 | 223,152,667 | 72% |
| NEW ENGLAND MUTUAL LIFE | 226,941,447 | 162,553,841 | 72% |
| LIFE INS. CO OF NO. AMERICAN | 333,735,648 | 238,670,267 | 72% |
| ST. PAUL LIFE INS. CO. | 72,151,279 | 51,532,157 | 71% |
| FARMLAND LIFE INS. CO. | 20,165,347 | 14,393,236 | 71% |
| AMERICAN NATIONAL INSURANCE | 60,156,922 | 42,785,364 | 71% |
| MUTUAL OF OMAHA INS. CO. | 1,632,415,721 | 1,160,696,109 | 71% |
| AETNA LIFE INS. CO. | 1,957,669,157 | 1,390,371,505 | 71% |
| CENTRAL LIFE ASSURANCE CO. | 64,847,502 | 45,931,256 | 71% |
| FIRST NATIONAL LIFE - AL | 12,595,025 | 8,919,333 | 71% |



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| WINTERTHUR SWISS INS. CO. | 14,716,036 | 9,267,010 | 63% |
| SAFECO LIFE INSURANCE CO. | 151,067,108 | 95,118,856 | 63% |
| PROVIDENT INDEMNITY LIFE | 13,853,752 | 8,718,911 | 63% |
| MACCABEES MUTUAL LIFE | 20,658,823 | 12,976,304 | 63% |
| LIFE & CASUALTY OF TN. | 34,318,430 | 21,528,455 | 63% |
| AMERICAN STATES INS. CO. | 33,485,678 | 21,005,566 | 63% |
| UNITED LIFE & ACCIDENT | 20,578,024 | 12,901,878 | 63% |
| PEKIN LIFE INS. CO. | 19,125,395 | 11,897,802 | 62% |
| NATIONAL CASUALTY CO. | 48,341,698 | 30,067,124 | 62% |
| AMERICAN BANKERS INS. CO. | 11,256,691 | 6,995,852 | 62% |
| NATIONAL BENEFIT LIFE | 41,242,553 | 25,535,068 | 62% |
| KENTUCKY CENTRAL LIFE | 17,827,141 | 11,027,365 | 62% |
| FEDERAL HOME LIFE INS. CO. | 55,018,110 | 33,900,447 | 62% |
| WASHINGTON NATIONAL INSURANCE | 219,700,128 | 135,323,412 | 62% |
| ALL AMERICAN LIFE | 22,761,169 | 14,014,307 | 62% |
| AMERICAN LIFE & CAS. INS. | 29,637,314 | 18,222,343 | 61% |
| BOSTON MUTUAL LIFE | 18,888,679 | 11,555,992 | 61% |
| LIFE INVESTORS INS/AMER | 63,400,124 | 38,500,144 | 61% |
| SECURITY OF AMER. LIFE INS. | 20,415,038 | 12,336,451 | 60% |
| CUDIS INS. SOCIETY INC. | 125,786,925 | 75,904,358 | 60% |
| NATIONAL LIFE INS. CO., VT | 22,534,475 | 13,593,432 | 60% |
| JOHN ALDEN LIFE INS. CO. | 156,713,543 | 94,532,751 | 60% |
| WORLD INSURANCE CO. | 24,734,991 | 14,883,396 | 60% |
| ZURICH INS. CO. | 28,799,180 | 17,295,700 | 60% |
| MUTUAL SECURITY LIFE INS. | 87,198,309 | 52,033,072 | 60% |
| BANKERS UNITED LIFE ASSUR. | 36,275,774 | 21,426,020 | 59% |
| BANKERS MULTIPLE LINE INS. | 30,854,283 | 18,068,252 | 59% |
| WABASH LIFE INS. CO. | 11,316,909 | 6,626,654 | 59% |
| PHYSICIANS MUTUAL INS. CO. | 203,960,369 | 119,032,182 | 58% |
| NATIONAL LIFE & ACCIDENT | 95,882,234 | 55,936,457 | 58% |
| AMERICAN ROAD INS. | 22,191,484 | 12,851,344 | 58% |
| MONUMENTAL LIFE INS. | 24,650,735 | 14,201,221 | 58% |
| GENERAL REASSURANCE CORP. | 38,057,515 | 21,919,150 | 58% |
| CENTRAL RESERVE LIFE-NA | 51,434,767 | 29,468,332 | 57% |
| INTER-OCEAN INS. CO. | 43,296,579 | 24,768,062 | 57% |
| MIC LIFE INS. CORP. | 10,409,129 | 5,901,638 | 57% |
| ZALE LIFE INS. CO. | 11,267,808 | 6,384,109 | 57% |
| PAUL REVERE LIFE INS. CO. | 222,300,253 | 125,873,535 | 57% |
| CONNECTICUT MUTUAL LIFE | 32,781,309 | 18,521,743 | 57% |
| AETNA LIFE INS. & ANNUITY | 29,794,025 | 16,821,256 | 56% |
| FORUM INSURANCE CO. | 10,501,509 | 5,912,237 | 56% |
| GOLDEN RULE INSURANCE CO. | 131,094,142 | 73,751,534 | 56% |
| BLUE ALLIANCE MUTUAL INS. | 22,262,185 | 12,446,175 | 56% |
| IDS LIFE INS. CO. | 22,156,995 | 12,386,444 | 56% |
| AIG LIFE INSURANCE CO. | 49,113,954 | 27,413,047 | 56% |
| AMERICAN STANDARD L & A | 11,807,093 | 6,581,537 | 56% |
| PROVIDENT ALLIANCE LIFE | 42,863,764 | 23,647,906 | 55% |
| VETERANS LIFE INS. CO. | 11,527,676 | 6,353,360 | 55% |
| NATIONAL HOME LIFE ASSUR. | 208,304,925 | 114,517,368 | 55% |
| UNION BANKERS INS. CO. | 68,866,507 | 37,703,158 | 55% |
| AMERICAN INDEPENDENT INS. | 10,876,697 | 5,949,859 | 55% |
| BENEFICIAL STANDARD LIFE | 27,005,734 | 14,766,074 | 55% |
| NATIONAL LIBERTY LIFE INS. | 23,808,583 | 12,975,015 | 54% |
| MONUMENTAL GENL. INS. CO. | 18,709,626 | 10,069,065 | 54% |
| PIONEER LIFE INS. CO. OF IL. | 31,520,933 | 16,936,461 | 54% |
| LIBERTY NATIONAL LIFE INS. | 109,390,251 | 58,772,930 | 54% |



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|---|---|---|---|
| PROVIDENT LIFE & ACCID. CO. | 553,331,705 | 391,705,388 | 71% |
| CAMPANION LIFE INS. - NY | 23,523,983 | 16,618,672 | 71% |
| COMMERCIAL BANKERS LIFE | 19,059,916 | 13,452,904 | 71% |
| BEST LIFE ASSUR. CO. CA | 14,419,430 | 10,111,648 | 70% |
| NATIONAL SAVINGS LIFE - TN | 10,598,127 | 7,431,457 | 70% |
| CUNA MUTUAL INS. SOCIETY | 54,560,029 | 38,219,547 | 70% |
| DURHAM LIFE INSURANCE CO. | 90,557,309 | 63,319,933 | 70% |
| LUMBERMENS LIFE INS. CO. | 22,981,394 | 16,065,654 | 70% |
| WESTERN LIFE INSURANCE CO. | 44,494,014 | 31,085,338 | 70% |
| GUARANTEE TRUST LIFE INS. | 44,128,284 | 30,631,133 | 69% |
| STATE MUT. LIFE ASSUR. AMER. | 238,855,974 | 165,507,324 | 69% |
| COUNTRY LIFE INS. CO. | 75,907,797 | 52,245,056 | 69% |
| INVESTORS HERITAGE LIFE | 11,347,089 | 7,787,039 | 69% |
| APPLACHIAN NATL. LIFE INS. | 19,696,517 | 13,488,030 | 68% |
| UNIONMUTUAL STOCK LIFE AM. | 385,481,172 | 263,598,690 | 68% |
| GREAT REPUBLIC LIFE OF CA. | 31,326,108 | 21,386,839 | 68% |
| BANKERS LIFE OF NEB. | 43,034,472 | 29,321,955 | 68% |
| SHELTER LIFE INS. CO. | 64,574,668 | 43,829,193 | 68% |
| PHOENIX MUTUAL LIFE INS. | 135,418,679 | 91,749,936 | 68% |
| AMERICAN FIDELITY ASSUR. | 92,901,576 | 62,662,038 | 67% |
| AMERICAN CHAMBERS LIFE | 50,413,893 | 33,948,184 | 67% |
| METROPOLITAN LIFE INS. CO. | 1,462,106,272 | 982,140,216 | 67% |
| HARBOR INSURANCE CO. | 16,633,096 | 11,137,648 | 67% |
| ASSOCIATION LIFE INSURANCE CO. | 44,302,851 | 29,639,255 | 67% |
| SENTRY LIFE INSURANCE CO. | 208,520,584 | 139,157,803 | 67% |
| SPRINGFIELD LIFE INS. | 10,766,254 | 7,151,245 | 66% |
| NEW YORK LIFE INS. CO. | 863,753,678 | 573,572,579 | 66% |
| COMMONWEALTH LIFE INS. - KY | 21,412,722 | 14,214,250 | 66% |
| NORTH AMER. LIFE & CAS. CO. | 69,967,287 | 46,441,185 | 66% |
| CONNECTICUT NATIONAL | 15,591,951 | 10,336,217 | 66% |
| PACIFIC HERITAGE ASSUR. CO. | 18,877,546 | 12,502,620 | 66% |
| CELTIC LIFE INS.-R I | 23,880,306 | 15,763,907 | 66% |
| ORANGE STATE LIFE & HLTH. | 19,275,443 | 12,691,089 | 66% |
| ACADEMY LIFE INS. CO. | 10,318,354 | 6,780,773 | 66% |
| AID ASSN. FOR LUTHERANS-WI | 55,074,403 | 36,134,188 | 66% |
| BLC INSURANCE CO. | 45,028,360 | 29,514,373 | 66% |
| SAVERS LIFE INS. OF AMER. | 13,332,770 | 8,712,080 | 65% |
| SOUTHLAND LIFE INS. CO. | 31,816,282 | 20,765,156 | 65% |
| PHF LIFE INSURANCE CO. | 38,671,405 | 25,133,695 | 65% |
| N. N. INVESTORS LIFE INS. CO. | 155,993,635 | 101,259,221 | 65% |
| CENTENNIAL LIFE INS. CO. | 26,190,298 | 16,944,678 | 65% |
| MASSACHUSETTS CAS. INS. | 18,398,816 | 11,859,129 | 64% |
| TIME INSURANCE CO. | 261,727,208 | 168,438,483 | 64% |
| FOREMOST LIFE INS. | 15,925,791 | 10,243,670 | 64% |
| AMERICAN GENERAL LIFE DE. | 16,926,090 | 10,879,695 | 64% |
| PROVIDENT LIFE & CAS. INS. | 33,118,357 | 21,284,306 | 64% |
| SMA LIFE ASSUR. CO. | 15,746,765 | 10,102,861 | 64% |
| MINNESOTA MUTUAL LIFE INS. | 51,329,158 | 32,915,523 | 64% |
| STANDARD LIFE & ACCID. INS. | 48,678,888 | 31,206,258 | 64% |
| HOME INS. CO. | 14,684,608 | 9,408,031 | 64% |
| UNITED INS. CO. OF AMERICA | 145,957,279 | 93,403,035 | 64% |
| AMERICAN FAMILY MUTUAL | 114,478,978 | 73,224,831 | 64% |
| MONARCH LIFE INS. CO. | 60,964,578 | 38,946,356 | 64% |
| LONE STAR LIFE INS. CO. | 77,726,097 | 49,524,862 | 64% |
| UNITED FOUNDERS LIFE - OK | 10,838,264 | 6,884,699 | 64% |
| PYRAMID LIFE INSURANCE CO. | 37,177,325 | 23,414,548 | 63% |



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| INTERCONTINENTAL LIFE INS. | 14,910,574 | 8,003,680 | 54% |
| NATL. HOME LIFE ASSUR. - NY | 13,726,241 | 7,340,332 | 54% |
| GLOBE LIFE & ACCIDENT INS. | 81,304,107 | 43,477,748 | 53% |
| AMERICAN INCOME LIFE INS. | 25,773,413 | 13,764,297 | 53% |
| OLD SOUTHERN LIFE INS. CO. | 11,640,231 | 6,135,845 | 53% |
| CERTIFIED LIFE INS. CO-CA | 49,202,770 | 25,921,746 | 53% |
| FIRST CONTINENTAL L & A INS. | 11,199,888 | 5,858,328 | 52% |
| PENNSYLVANIA LIFE INS. CO. | 94,923,054 | 48,774,600 | 51% |
| INDEPENDENT LIFE & ACCID. | 122,698,529 | 62,776,057 | 51% |
| GEORGE WASHINGTON LIFE CO. | 19,591,951 | 9,989,373 | 51% |
| EQUITABLE LIFE & CAS. INS. | 24,274,469 | 12,356,093 | 51% |
| AMERICAN SERVICE LIFE - TX | 16,385,994 | 8,213,300 | 50% |
| CENTRAL STATES HLTH & LIFE | 54,897,581 | 27,185,984 | 50% |
| INS. CO. OF NORTH AMERICA | 11,608,492 | 5,715,892 | 49% |
| AMERICAN REPUBLIC INS. CO. | 73,247,888 | 35,656,749 | 49% |
| AMERICAN HOME ASSUR. CO. | 11,654,764 | 5,670,763 | 49% |
| RESERVE NATIONAL INS. CO. | 32,665,795 | 15,864,809 | 49% |
| AMERICAN LIFE INS. CO-DE | 76,736,419 | 36,838,050 | 48% |
| ARCADIA INSURANCE CO. | 10,089,785 | 4,823,666 | 48% |
| FIRST HORIZON INS. | 18,036,741 | 8,589,223 | 48% |
| LUTHERAN BROTHERHOOD | 17,640,090 | 8,356,433 | 47% |
| NORTHWESTERN MUTUAL LIFE | 81,136,147 | 38,225,661 | 47% |
| CONTINENTAL AMER. LIFE INS. | 22,796,027 | 10,730,870 | 47% |
| MASSACHUSETTS IND. & LIFE | 133,527,315 | 62,411,422 | 47% |
| OLD AMERICAN INS. CO. | 18,300,907 | 8,546,542 | 47% |
| MERIT LIFE INS. CO. | 28,521,550 | 13,178,947 | 46% |
| AMERICAN BANKERS LIFE FLA | 48,867,410 | 22,390,935 | 46% |
| COLONIAL LIFE & ACCID. INS. | 123,813,806 | 56,552,460 | 46% |
| WORLD LIFE & HEALTH INS. | 11,243,961 | 5,108,198 | 45% |
| NATIONAL STATES INS. CO. | 25,626,852 | 11,558,308 | 45% |
| MONTGOMERY WARD LIFE INS. | 64,871,263 | 29,078,027 | 45% |
| CONTINENTAL GENERAL INS. | 17,756,872 | 7,911,476 | 45% |
| MUTUAL PROTECTIVE INS. CO. | 35,295,954 | 15,575,207 | 44% |
| UNITED AMERICAN INS. CO. | 216,629,860 | 94,736,773 | 44% |
| CREDIT LIFE INSURANCE CO. | 24,762,099 | 10,816,892 | 44% |
| GEORGIA CAS. & SUR. CO. | 20,299,682 | 8,682,218 | 43% |
| MUTUAL SAVINGS LIFE INS. | 12,717,679 | 5,408,379 | 43% |
| MID-CONTINENT CASUALTY CO. | 38,901,115 | 16,105106 | 41% |
| EQUITY NATIONAL LIFE INS. | 19,029,890 | 7,803,195 | 41% |
| IMPERIAL CAS. & INDEMN. CO. | 11,104,674 | 4,548,758 | 41% |
| J. C. PENNEY LIFE INS. CO. | 49,200,141 | 20,092,898 | 41% |
| AMER. FAMILY LIFE ASSUR. | 664,070,240 | 270,273,609 | 41% |
| AIU INS. CO. | 18,937,872 | 7,660,618 | 40% |
| EXECUTIVE FUND LIFE INS. | 34,328,508 | 13,842,449 | 40% |
| EAGLE LIFE INS. CO. | 18,059,696 | 7,196,819 | 40% |
| COMBINED LIFE INS. CO-NY | 29,717,535 | 11,826,089 | 40% |
| PENINSULAR LIFE INS. CO. | 14,054,904 | 5,590,015 | 40% |
| COMBINED INS. CO. OF AMERICA | 536,419,373 | 210,009,276 | 39% |
| UNITED EQUITABLE INS. | 12,198,853 | 4,664,134 | 38% |
| LOYAL AMERICAN LIFE INS. | 13,541,179 | 5,089,490 | 38% |
| CUMBERLAND LIFE INS. TENN. | 27,900,013 | 10,333,959 | 37% |
| CONTINENTAL LIFE INS. TX | 12,023,789 | 4,431,757 | 37% |
| BANNER LIFE INS. | 17,300,135 | 6,374,875 | 37% |
| HERITAGE LIFE INS. CO. | 12,052,051 | 4,376,167 | 36% |
| TRANSPORT LIFE INS. CO. | 44,168,532 | 15,890,150 | 36% |
| FIREMANS FUND AMER. LIFE | 82,669,574 | 29,659,755 | 36% |



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| LYNDON INSURANCE CO. | 34,467,324 | 11,839,777 | 34% |
| UNION NATL. LIFE INS. OF LA | 16,621,736 | 5,740,980 | 35% |
| NORTH CENTRAL LIFE INS. CO. | 19,083,200 | 6,089,407 | 32% |
| MIDLAND MUTUAL LIFE INS. | 19,634,469 | 3,358,137 | 32% |
| PAUL REVERE PROT. LIFE | 44,111,986 | 13,601,276 | 31% |
| FIDELITY SECURITY LIFE CO. | 13,153,015 | 3,924,131 | 30% |
| AMERICAN INTEGRITY INS. CO. | 11,954,742 | 3,548,255 | 30% |
| CENTRAL STATES INDEMNITY | 14,198,432 | 3,922,016 | 28% |
| BERKSHIRE LIFE INS. CO. | 12,400,729 | 3,255,781 | 26% |
| NRG. AMERICA LIFE REASSUR. | 77,604,227 | 19,297,949 | 25% |
| GLOBE LIFE INS. CO. | 26,189,900 | 6,070,707 | 23% |
| JMIC LIFE INS. CO. | 10,478,972 | 1,988,264 | 19% |
| TRAVERLERS INDEMNITY | 50,914,607 | 9,469,615 | 19% |
| CENTRAL NATL. INS. CO. - OMAHA | 17,134,868 | 2,129,270 | 12% |
| LIFE ASSUR. CO. OF PA. | 11,887,297 | 1,180,662 | 10% |
| PRUDENTIAL REINS. CO. | 42,336,990 | 3,591,388 | 8% |
| AMERICAN WAY LIFE INS. | 10,720,882 | 892,677 | 8% |



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APPENDIX E-3

PREMIUMS--CLAIMS--LOSS RATIO
ALPHABETICAL LISTING BY COMPANY NAME

| COMPANY | PREMIUMS EARNED LESS DIVIDENDS (DOLLARS) | CLAIMS INCURRED (DOLLARS) | LOSS RATIO |
|---|---|---|---|
| ACADEMY LIFE INS. CO. | 10,318,354 | 6,780,773 | 66% |
| AETNA CAS. & SUR. OF ILL. | 93,562,947 | 100,936,284 | 108% |
| AETNA LIFE INS. & ANNUITY | 29,794,025 | 16,821,256 | 56% |
| AETNA LIFE INS. CO. | 1,957,669,157 | 1,390,371,505 | 71% |
| AETNA LIFE INS. CO. OF ILL. | 52,042,203 | 47,459,270 | 91% |
| AID ASSN. FOR LUTHERANS-WI | 55,074,403 | 36,134,188 | 66% |
| AIG LIFE INSURANCE CO. | 49,113,954 | 27,413,047 | 56% |
| AIU INS. CO. | 18,937,872 | 7,660,618 | 40% |
| ALEXANDER HAMILTON LIFE | 125,979,895 | 91,855,814 | 73% |
| ALL AMERICAN LIFE | 22,761,169 | 14,014,307 | 62% |
| ALLSTATE LIFE INS. | 627,152,318 | 560,695,986 | 89% |
| AMALGAMATED LABOR LIFE | 29,625,934 | 28,098,021 | 95% |
| AMER. FAMILY LIFE ASSUR. | 664,070,240 | 270,273,609 | 41% |
| AMER. MANUFACTURERS MUT. | 10,296,138 | 7,959,729 | 77% |
| AMERICAN BANKERS INS. CO. | 11,256,691 | 6,995,852 | 62% |
| AMERICAN BANKERS LIFE FLA | 48,867,410 | 22,390,935 | 46% |
| AMERICAN CASUALTY CO. | 11,994,624 | 8,895,292 | 74% |
| AMERICAN CHAMBERS LIFE | 50,413,893 | 33,948,184 | 67% |
| AMERICAN COMMUNITY MUTUAL | 134,185,472 | 97,817,736 | 73% |
| AMERICAN FAMILY MUTUAL | 114,478,978 | 73,224,831 | 64% |
| AMERICAN FIDELITY ASSUR. | 92,901,576 | 62,662,038 | 67% |
| AMERICAN GENERAL LIFE DE. | 16,926,090 | 10,879,695 | 64% |
| AMERICAN GENERAL LIFE TX. | 34,774,213 | 31,920,211 | 92% |
| AMERICAN HARDWARE MUTUAL | 31,736,486 | 26,752,199 | 84% |
| AMERICAN HERITAGE LIFE | 62,738,995 | 45,725,069 | 73% |
| AMERICAN HLTH. & LIFE INS. | 24,341,822 | 18,070,241 | 74% |
| AMERICAN HOME ASSUR. CO. | 11,654,764 | 5,670,763 | 49% |
| AMERICAN INCOME LIFE INS. | 25,773,413 | 13,764,297 | 53% |
| AMERICAN INDEPENDENT INS. | 10,876,697 | 5,949,859 | 55% |
| AMERICAN INTEGRITY INS. CO. | 11,954,742 | 3,548,255 | 30% |
| AMERICAN INTERNATL. LIFE | 30,378,579 | 22,829,831 | 75% |
| AMERICAN LIFE & CAS. INS. | 29,637,314 | 18,222,343 | 61% |
| AMERICAN LIFE INS. CO-DE | 76,736,419 | 36,838,050 | 48% |
| AMERICAN MOTORISTS INS. CO. | 42,887,284 | 32,553,447 | 76% |
| AMERICAN MUTUAL LIAB. INS. | 12,568,497 | 12,277,928 | 98% |
| AMERICAN NATIONAL INSURANCE | 60,156,922 | 42,783,364 | 71% |
| AMERICAN REPUBLIC INS. CO. | 73,247,888 | 35,656,749 | 49% |
| AMERICAN ROAD INS. | 22,191,484 | 12,851,344 | 58% |
| AMERICAN SECURITY LIFE | 24,242,287 | 18,986,185 | 78% |
| AMERICAN SERVICE LIFE - TX | 16,385,994 | 8,213,300 | 50% |
| AMERICAN STANDARD L & A | 11,807,093 | 6,581,537 | 56% |
| AMERICAN STATES INS. CO. | 33,485,678 | 21,005,566 | 63% |
| AMERICAN STATES LIFE INS. | 25,559,161 | 23,423,198 | 92% |
| AMERICAN UNITED LIFE INS. | 61,857,670 | 46,543,168 | 75% |
| AMERICAN WAY LIFE INS. | 10,720,882 | 892,677 | 8% |
| APPLACHIAN NATL. LIFE INS. | 19,696,617 | 13,488,030 | 68% |
| ARCADIA INSURANCE CO. | 10,089,785 | 4,823,666 | 48% |



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| ASSOCIATION LIFE INSURANCE CO. | 44,302,851 | 29,639,255 | 67% |
| BANKERS LIFE & CASUALTY | 502,961,365 | 369,080,173 | 73% |
| BANKERS LIFE OF NEB. | 43,004,472 | 29,321,955 | 68% |
| BANKERS LIFE, IA. | 804,810,831 | 590,624,012 | 73% |
| BANKERS MULTIPLE LINE INS. | 30,854,283 | 18,068,252 | 59% |
| BANKERS UNITED LIFE ASSUR. | 36,275,774 | 21,426,020 | 59% |
| BANNER LIFE INS. | 17,300,135 | 6,374,875 | 37% |
| BCS LIFE INSURANCE CO. | 49,041,092 | 42,549,609 | 87% |
| BENEFICIAL STANDARD LIFE | 27,005,734 | 14,766,074 | 55% |
| BENEFIT TRUST LIFE INS. CO. | 162,476,764 | 132,750,729 | 82% |
| BERKSHIRE LIFE INS. CO. | 12,400,729 | 3,255,781 | 26% |
| BEST LIFE ASSUR. CO. CA | 14,419,430 | 10,111,648 | 70% |
| BLC INSURANCE CO. | 45,028,360 | 29,514,373 | 66% |
| BLUE ALLIANCE MUTUAL INS. | 22,262,185 | 12,446,175 | 56% |
| BOSTON MUTUAL LIFE | 18,888,679 | 11,555,992 | 61% |
| BUSINESS MENS ASSUR. CO. | 118,128,989 | 86,533,160 | 73% |
| CAL-FARM LIFE | 35,131,270 | 30,536,697 | 87% |
| CALIFORNIA LIFE INS. CO. | 29,881,401 | 26,337,981 | 88% |
| CALIFORNIA PHYSICIANS INS. | 24,956,034 | 19,172,281 | 77% |
| CALIFORNIA WESTERN STATES | 50,859,051 | 65,841,872 | 129% |
| CAMPANION LIFE INS. - NY | 23,523,983 | 16,618,672 | 71% |
| CANADA LIFE ASSUR. CO. | 156,020,000 | 146,593,000 | 94% |
| CELTIC LIFE INS.-R I | 23,880,306 | 15,763,907 | 66% |
| CENTENNIAL LIFE INS. CO. | 26,190,298 | 16,944,678 | 65% |
| CENTRAL LIFE ASSURANCE CO. | 64,847,502 | 45,931,256 | 71% |
| CENTRAL NATL. INS. CO. - OMAHA | 17,134,868 | 2,129,270 | 12% |
| CENTRAL RESERVE LIFE-NA | 51,434,767 | 29,468,332 | 57% |
| CENTRAL STATES HLTH & LIFE | 54,897,581 | 27,185,984 | 50% |
| CENTRAL STATES INDEMNITY | 14,198,432 | 3,922,616 | 28% |
| CERTIFIED LIFE INS. CO-CA | 49,202,770 | 25,921,746 | 53% |
| COLOGNE LIFE REINS. CO. | 40,900,159 | 30,456,941 | 74% |
| COLONIAL LIFE & ACCID. INS. | 123,813,806 | 56,552,460 | 46% |
| COLONIAL LIFE INS. OF AMER. | 104,258,169 | 82,636,364 | 79% |
| COLONIAL PENN. LIFE INS. | 207,183,112 | 174,722,607 | 84% |
| COLUMBUS MUTUAL LIFE INS. | 27,474,581 | 22,358,096 | 81% |
| COMBINED INS. CO. OF AMERICA | 536,419,373 | 210,009,276 | 39% |
| COMBINED LIFE INS. CO-NY | 29,717,535 | 11,826,089 | 40% |
| COMMERCIAL BANKERS LIFE | 19,059,918 | 13,452,904 | 71% |
| COMMERCIAL LIFE INS. CO. | 156,749,883 | 113,834,065 | 73% |
| COMMONWEALTH LIFE INS. - KY | 21,412,762 | 14,214,250 | 66% |
| CONFEDERATION LIFE INS. CO. | 412,072,000 | 395,960,000 | 96% |
| CONNECTICUT GENERAL LIFE | 1,996,942,214 | 2,842,863,656 | 142% |
| CONNECTICUT MUTUAL LIFE | 32,781,309 | 18,521,743 | 57% |
| CONNECTICUT NATIONAL | 15,591,951 | 10,336,217 | 66% |
| CONSUMER BENEFIT LIFE | 15,484,934 | 11,141,742 | 72% |
| CONTINENTAL AMER. LIFE INS. | 22,796,027 | 10,730,870 | 47% |
| CONTINENTAL ASSUR. CO. | 928,594,628 | 798,698,825 | 86% |
| CONTINENTAL CASUALTY CO. | 111,327,238 | 82,561,020 | 74% |
| CONTINENTAL GENERAL INS. | 17,756,872 | 7,911,476 | 45% |
| CONTINENTAL LIFE & ACCIDENT | 41,784,132 | 33,454,585 | 80% |
| CONTINENTAL LIFE INS. TX | 12,023,789 | 4,431,757 | 37% |
| COOPERANTS MUT. LIFE SOCY. | 15,722,000 | 11,788,000 | 75% |
| COUNTRY LIFE INS. CO. | 75,907,797 | 52,245,056 | 69% |
| CREDIT LIFE INSURANCE CO. | 24,762,099 | 10,816,892 | 44% |
| CROWN LIFE INS. CO. | 462,124,000 | 371,443,000 | 80% |
| CUDIS INS. SOCIETY INC. | 125,786,925 | 75,904,358 | 60% |



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| CUMB RLAND LIFE INS. TENN. | 27,900,013 | 10,333,959 | 37% |
| CUNA MUTUAL INS. SOCIETY | 54,560,029 | 38,219,547 | 70% |
| DEPENDABLE LIFE INS. CO. - FL. | 17,133,126 | 13,241,052 | 77% |
| DOMINION LIFE ASSURANCE | 43,092,000 | 39,938,000 | 93% |
| DURHAM LIFE INSURANCE CO. | 90,557,309 | 63,319,933 | 70% |
| EAGLE LIFE INS. CO. | 18,059,696 | 7,196,819 | 40% |
| EDUCATORS MUTUAL LIFE INS. | 37,130,639 | 30,118,401 | 81% |
| EMPLOYERS REINS. CORP. | 159,173,792 | 154,439,837 | 97% |
| EQUITABLE CAS. INS. CO. | 50,565,091 | 57,542,085 | 114% |
| EQUITABLE LIFE & CAS. INS. | 24,274,469 | 12,356,093 | 51% |
| EQUITABLE LIFE ASSUR. SOCY. | 690,289,990 | 568,498,921 | 82% |
| EQUITY NATIONAL LIFE INS. | 19,029,890 | 7,803,195 | 41% |
| EXECUTIVE FUND LIFE INS. | 34,328,508 | 13,842,449 | 40% |
| FARMERS NEW WORLD LIFE CO. | 30,348,638 | 24,920,444 | 82% |
| FARMLAND LIFE INS. CO. | 20,165,347 | 14,393,236 | 71% |
| FEDERAL HOME LIFE INS. CO. | 55,018,110 | 33,900,447 | 62% |
| FEDERATED MUTUAL INS. CO. | 87,094,100 | 69,523,017 | 80% |
| FIDELITY SECURITY LIFE CO. | 13,153,025 | 3,924,131 | 30% |
| FIREMANS FUND AMER. LIFE | 82,669,574 | 29,659,755 | 36% |
| FIREMENS FUND EMPLOYERS | 311,313,956 | 223,152,667 | 72% |
| FIRST CONTINENTAL L & A INS. | 11,199,888 | 5,858,328 | 52% |
| FIRST DELAWARE LIFE | 17,060,716 | 14,425,722 | 85% |
| FIRST HORIZON INS. | 18,036,741 | 8,589,223 | 48% |
| FIRST NATIONAL LIFE - AL | 12,595,025 | 8,919,333 | 71% |
| FOREMOST LIFE INS. | 15,925,791 | 10,243,670 | 64% |
| FORUM INSURANCE CO. | 10,501,509 | 5,912,237 | 56% |
| GENERAL AMERICAN LIFE INS. | 318,109,594 | 263,463,324 | 83% |
| GENERAL REASSURANCE CORP. | 38,057,515 | 21,919,150 | 58% |
| GEORGE WASHINGTON LIFE CO. | 19,591,951 | 9,989,373 | 51% |
| GEORGIA CAS. & SUR. CO. | 20,299,682 | 8,682,218 | 43% |
| GEORGIA INTERNATL LIFE CO. | 32,847,626 | 24,911,290 | 76% |
| GERLING GLOBAL REINS. CORP. | 10,359,204 | 8,652,105 | 84% |
| GLOBE LIFE & ACCIDENT INS. | 81,304,107 | 43,477,748 | 53% |
| GLOBE LIFE INS. CO. | 26,189,900 | 6,070,707 | 23% |
| GOLDEN RULE INSURANCE CO. | 131,094,142 | 73,751,534 | 56% |
| GREAT AMERICAN RESERVE CO. | 29,106,243 | 22,383,348 | 77% |
| GREAT REPUBLIC LIFE OF CA. | 31,326,108 | 21,386,839 | 68% |
| GREAT SOUTHERN LIFE INS. | 47,075,608 | 36,373,766 | 77% |
| GREAT-WEST LIFE ASSUR. | 519,024,000 | 460,441,000 | 89% |
| GROUP LIFE & HEALTH INS. | 60,085,854 | 58,534,396 | 97% |
| GUARANTEE MUTUAL LIFE CO. | 27,248,471 | 21,875,557 | 80% |
| GUARANTEE TRUST LIFE INS. | 44,128,284 | 30,631,133 | 69% |
| GUARDIAN LIFE OF AMERICA | 539,946,089 | 417,975,453 | 77% |
| GULF LIFE GROUP INS. CO. | 54,235,663 | 49,617,889 | 91% |
| GULF LIFE INSURANCE CO. | 178,253,567 | 141,141,960 | 79% |
| HARBOR INSURANCE CO. | 16,633,096 | 11,137,648 | 67% |
| HARTFORD LIFE & ACCIDENT | 496,053,062 | 407,429,714 | 82% |
| HERITAGE LIFE INS. CO. | 12,052,051 | 4,376,167 | 36% |
| HOME INS. CO. | 14,684,608 | 9,408,031 | 64% |
| HOME LIFE INSURANCE CO. | 142,780,666 | 116,789,755 | 82% |
| HOME SECURITY LIFE INS-NC | 27,319,382 | 21,700,778 | 79% |
| HORACE MANN LIFE INS. CO. | 61,268,187 | 45,985,519 | 75% |
| IDS LIFE INS. CO. | 22,156,995 | 12,386,444 | 56% |
| ILLINOIS MUTUAL LIFE & CAS. | 35,254,433 | 25,366,777 | 72% |
| IMPERIAL CAS. & INDEMN. CO. | 11,104,674 | 4,548,758 | 41% |
| INA LIFE INSURANCE OF NY | 39,295,522 | 29,110,986 | 74% |



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|---|---|---|---|
| MUTUAL PROTECTIVE INS. CO. | 35,295,954 | 15,575,207 | 44% |
| MUTUAL SAVINGS LIFE INS. | 12,717,679 | 5,408,379 | 43% |
| MUTUAL SECURITY LIFE INS. | 87,198,309 | 52,033,072 | 60% |
| MUTUAL SERVICE LIFE INS. | 38,444,527 | 28,926,901 | 75% |
| N. N. INVESTORS LIFE INS. CO. | 155,993,635 | 101,259,221 | 65% |
| NATIONAL BENEFIT LIFE | 41,242,553 | 25,535,068 | 62% |
| NATIONAL CASUALTY CO. | 48,341,698 | 30,067,124 | 62% |
| NATIONAL FARMERS UNION | 16,622,861 | 12,653,016 | 76% |
| NATIONAL FIRE INS. | 29,129,798 | 21,602,853 | 74% |
| NATIONAL HOME LIFE ASSUR. | 208,304,925 | 114,517,368 | 55% |
| NATIONAL LIBERTY LIFE INS. | 23,808,583 | 12,975,015 | 54% |
| NATIONAL LIFE & ACCIDENT | 95,882,234 | 55,936,457 | 58% |
| NATIONAL LIFE INS. CO., VT | 22,534,475 | 13,593,432 | 60% |
| NATIONAL SAVINGS LIFE - TN | 10,598,127 | 7,431,457 | 70% |
| NATIONAL STATES INS. CO. | 25,626,852 | 11,558,308 | 45% |
| NATIONAL TRAVELERS LIFE | 15,497,656 | 11,426,856 | 74% |
| NATIONWIDE MUTUAL FIRE | 39,299,598 | 31,248,106 | 80% |
| NATIONWIDE MUTUAL INS. CO. | 238,604,700 | 189,720,645 | 80% |
| NATL. HOME LIFE ASSUR. - NY | 13,726,241 | 7,346,332 | 54% |
| NEW ENGLAND GEN. LIFE INS. | 12,108,928 | 13,961,242 | 115% |
| NEW ENGLAND MUTUAL LIFE | 226,941,447 | 162,553,841 | 72% |
| NEW YORK LIFE INS. CO. | 863,753,678 | 573,572,579 | 66% |
| NORTH AMER. CO/L&H INS. | 13,685,106 | 18,749,564 | 137% |
| NORTH AMER. LIFE & CAS. CO. | 69,967,287 | 46,441,185 | 66% |
| NORTH AMERICAN REINS. CO. | 41,530,415 | 40,920,511 | 99% |
| NORTH CAROLINA MUT. LIFE | 13,391,539 | 10,669,725 | 80% |
| NORTH CENTRAL LIFE INS. CO. | 19,085,200 | 6,089,407 | 32% |
| NORTHBROOK LIFE INS. | 31,673,840 | 27,939,332 | 88% |
| NORTHWESTERN MUTUAL LIFE | 81,136,147 | 38,225,661 | 47% |
| NORTHWESTERN NATL. LIFE | 128,501,105 | 93,806,944 | 73% |
| NRG. AMERICA LIFE REASSUR. | 77,604,227 | 19,297,949 | 25% |
| OHIO STATE LIFE INS. CO. | 145,733,225 | 111,023,471 | 76% |
| OLD AMERICAN INS. CO. | 18,300,907 | 8,546,542 | 47% |
| OLD SOUTHERN LIFE INS. CO. | 11,640,231 | 6,135,845 | 53% |
| ORANGE STATE LIFE & HLTH. | 19,275,443 | 12,691,089 | 66% |
| OXFORD LIFE INS. CO. | 32,097,368 | 24,766,362 | 77% |
| PACIFIC HERITAGE ASSUR. CO. | 18,877,546 | 12,502,620 | 66% |
| PACIFIC MUTUAL LIFE INS. | 283,812,801 | 204,738,563 | 72% |
| PAN-AMERICAN LIFE INS. CO. | 78,937,833 | 60,960,709 | 77% |
| PAUL REVERE LIFE INS. CO. | 222,300,253 | 125,873,535 | 57% |
| PAUL REVERE PROT. LIFE | 44,111,986 | 13,601,276 | 31% |
| PAULA INS. CO. | 22,422,321 | 18,706,478 | 83% |
| PEERLESS INS. CO. | 10,911,258 | 8,927,586 | 82% |
| PEKIN LIFE INS. CO. | 19,125,395 | 11,897,802 | 62% |
| PENINSULAR LIFE INS. CO. | 14,054,904 | 5,590,015 | 40% |
| PENNSYLVANIA LIFE INS. CO. | 94,923,054 | 48,774,600 | 51% |
| PHF LIFE INSURANCE CO. | 38,671,405 | 25,133,695 | 65% |
| PHILADELPHIA AMERICAN LIFE | 44,439,114 | 39,385,768 | 89% |
| PHOENIX MUTUAL LIFE INS. | 135,418,679 | 91,749,936 | 68% |
| PHYSICIANS MUTUAL INS. CO. | 203,960,369 | 119,032,182 | 58% |
| PILOT LIFE INSURANCE CO. | 343,620,698 | 279,700,231 | 81% |
| PIONEER LIFE INS. CO. OF IL. | 31,520,933 | 16,936,461 | 54% |
| PROTECTIVE LIFE INS. CO. | 63,605,474 | 49,013,300 | 77% |
| PROVIDENT ALLIANCE LIFE | 42,863,764 | 23,647,906 | 55% |
| PROVIDENT GENERAL INS. CO. | 12,186,135 | 15,734,670 | 129% |
| PROVIDENT INDEMNITY LIFE | 13,853,752 | 8,718,911 | 63% |



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|---|---|---|---|
| INDEPENDENT LIFE & ACCID. | 122,698,529 | 62,776,057 | 51% |
| INS. CO. OF NORTH AMERICA | 11,608,492 | 5,715,892 | 49% |
| INTER-OCEAN INS. CO. | 43,296,579 | 24,768,062 | 57% |
| INTERCONTINENTAL LIFE - PR | 19,586,098 | 14,499,958 | 74% |
| INTERCONTINENTAL LIFE INS. | 14,910,224 | 8,002,686 | 54% |
| INTRAMERICA LIFE INS. CO. | 14,755,061 | 13,819,958 | 94% |
| INVESTORS HERITAGE LIFE | 11,347,089 | 7,787,039 | 69% |
| J. C. PENNEY LIFE INS. CO. | 49,200,141 | 20,092,898 | 41% |
| JMIC LIFE INS. CO. | 10,478,972 | 1,988,264 | 19% |
| JOHN ALDEN LIFE INS. CO. | 156,713,543 | 94,532,751 | 60% |
| JOHN DEERE INS. CO. | 29,681,215 | 28,629,747 | 96% |
| JOHN HANCOCK MUT. LIFE INS. | 586,864,184 | 459,934,313 | 78% |
| KENTUCKY CENTRAL LIFE | 17,827,141 | 11,027,365 | 62% |
| LAMAR LIFE INS. CO. | 19,102,487 | 14,333,128 | 75% |
| LIBERTY LIFE ASSUR./BOSTON | 18,821,353 | 16,579,960 | 88% |
| LIBERTY LIFE INSURANCE CO. | 55,720,630 | 41,911,417 | 75% |
| LIBERTY MUT. FIRE INS. CO. | 18,084,417 | 15,876,658 | 88% |
| LIBERTY MUTUAL INS. CO. | 162,759,741 | 142,889,919 | 88% |
| LIBERTY NATIONAL LIFE INS. | 109,390,251 | 58,772,930 | 54% |
| LIFE & CASUALTY OF TN. | 34,318,430 | 21,528,455 | 63% |
| LIFE ASSUR. CO. OF PA. | 11,887,297 | 1,180,662 | 10% |
| LIFE INS. CO OF NO. AMERICAN | 333,735,648 | 238,670,267 | 72% |
| LIFE INS. CO. OF GEORGIA | 80,425,387 | 59,098,800 | 73% |
| LIFE INS. CO. OF SOUTHWEST | 14,341,498 | 10,634,593 | 74% |
| LIFE INS. CO. OF VIRGINIA | 55,596,907 | 44,354,473 | 80% |
| LIFE INVESTORS INS/AMER | 63,400,124 | 38,500,144 | 61% |
| LINCOLN NATIONAL LIFE INS. | 904,287,298 | 674,843,359 | 75% |
| LONE STAR LIFE INS. CO. | 77,726,097 | 49,524,862 | 64% |
| LOYAL AMERICAN LIFE INS. | 13,541,179 | 5,089,490 | 38% |
| LUMBERMENS LIFE INS. CO. | 22,981,394 | 16,065,654 | 70% |
| LUMBERMENS MUT. CAS. CO. | 104,303,718 | 80,531,375 | 77% |
| LUTHERAN BROTHERHOOD | 17,640,090 | 8,356,433 | 47% |
| LYNDON INS CO. | 40,718,000 | 31,848,000 | 78% |
| LYNDON INSURANCE CO. | 34,467,324 | 12,239,777 | 36% |
| MACCABEES MUTUAL LIFE | 20,658,823 | 12,976,304 | 63% |
| MANUFACTURERS LIFE INS. CO. | 24,733,000 | 22,395,000 | 91% |
| MASSACHUSETTS CAS. INS. | 18,398,816 | 11,859,129 | 64% |
| MASSACHUSETTS IND. & LIFE | 133,527,315 | 62,411,422 | 47% |
| MASSACHUSETTS MUTUAL LIFE | 376,717,942 | 272,825,632 | 72% |
| MENNONITE MUTUAL AID ASSN. | 28,828,031 | 23,393,567 | 81% |
| MERIT LIFE INS. CO. | 28,521,550 | 13,178,947 | 46% |
| METROPOLITAN LIFE INS. CO. | 1,462,106,272 | 982,140,216 | 67% |
| METROPOLITAN PROP. & LIAB. | 43,500,430 | 89,262,889 | 205% |
| MIC LIFE INS. CORP. | 10,409,129 | 5,901,638 | 57% |
| MICHIGAN LIFE INS. CO. | 19,990,108 | 17,548,777 | 88% |
| MID-CONTINENT CASUALTY CO. | 38,901,115 | 16,105,106 | 41% |
| MIDLAND MUTUAL LIFE INS. | 10,634,469 | 3,358,137 | 32% |
| MINISTERS LIFE & MUTUAL | 12,465,911 | 10,941,580 | 88% |
| MINNESOTA MUTUAL LIFE INS. | 51,329,158 | 32,915,523 | 64% |
| MONARCH LIFE INS. CO. | 60,964,578 | 38,946,556 | 64% |
| MONTGOMERY WARD LIFE INS. | 64,871,263 | 29,078,027 | 45% |
| MONUMENTAL GENL. INS. CO. | 18,709,626 | 10,069,065 | 54% |
| MONUMENTAL LIFE INS. | 24,650,735 | 14,201,221 | 58% |
| MUTUAL BENEFIT LIFE INS. | 382,154,253 | 288,466,753 | 75% |
| MUTUAL LIFE OF NEW YORK | 252,466,444 | 181,704,425 | 72% |
| MUTUAL OF OMAHA INS. CO. | 1,632,415,721 | 1,160,696,109 | 71% |



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|---|---|---|---|
| PROVIDENT LIFE & ACCID. CO. | 553,331,705 | 391,705,380 | 71% |
| PROVIDENT LIFE & CAS. INS. | 33,118,357 | 21,284,306 | 64% |
| PROVIDENT MUTUAL LIFE INS. | 116,514,445 | 84,611,437 | 73% |
| PRUDENTIAL INS. OF AMER. | 2,702,628,771 | 2,099,725,986 | 78% |
| PRUDENTIAL PROP. & CAS. INS. | 89,963,879 | 87,071,464 | 97% |
| PRUDENTIAL REINS. CO. | 42,336,990 | 3,591,388 | 8% |
| PURITAN LIFE INSURANCE CO. | 230,797,168 | 198,653,210 | 86% |
| PYRAMID LIFE INSURANCE CO. | 37,177,325 | 23,414,540 | 63% |
| RELIANCE INSURANCE CO. | 37,963,344 | 30,455,945 | 80% |
| RELIANCE STANDARD LIFE | 52,742,095 | 41,683,363 | 79% |
| REPUBLIC NATL. LIFE GROUP | 204,256,834 | 166,167,434 | 81% |
| RESERVE LIFE INSURANCE CO. | 107,603,049 | 86,375,818 | 80% |
| RESERVE NATIONAL INS. CO. | 32,665,795 | 15,864,809 | 49% |
| RURAL MUTUAL INS. | 10,102,229 | 8,244,528 | 82% |
| RURAL SECURITY LIFE INS. | 41,104,722 | 32,431,627 | 79% |
| SAFECO LIFE INSURANCE CO. | 151,067,108 | 95,118,856 | 63% |
| SAVERS LIFE INS. OF AMER. | 13,332,770 | 8,712,080 | 65% |
| SECURITY MUTUAL LIFE NY | 10,721,919 | 7,971,778 | 74% |
| SECURITY MUTUAL LIFE, NE | 11,482,174 | 10,545,745 | 92% |
| SECURITY OF AMER. LIFE INS. | 20,415,038 | 12,336,451 | 60% |
| SENTRY INS. CO. A. MUTUAL | 14,915,804 | 12,687,068 | 85% |
| SENTRY LIFE INSURANCE CO. | 208,520,584 | 139,157,803 | 67% |
| SHELTER LIFE INS. CO. | 64,574,668 | 43,829,193 | 68% |
| SIERRA GENERAL LIFE INS. | 11,554,583 | 10,683,251 | 92% |
| SMA LIFE ASSUR. CO. | 15,746,765 | 10,102,861 | 64% |
| SOUTHLAND LIFE INS. CO. | 31,816,282 | 20,765,156 | 65% |
| SPRINGFIELD LIFE INS. | 10,766,254 | 7,151,245 | 66% |
| ST. PAUL LIFE INS. CO. | 72,151,279 | 51,532,157 | 71% |
| STANDARD INSURANCE CO. | 98,981,206 | 85,976,440 | 87% |
| STANDARD LIFE & ACCID. INS. | 48,678,888 | 31,206,258 | 64% |
| STATE FARM MUTUAL AUTO. | 463,010,357 | 343,630,626 | 74% |
| STATE MUT. LIFE ASSUR. AMER. | 238,855,974 | 165,507,324 | 69% |
| SUN LIFE ASSUR. CO. CANADA | 268,918,000 | 277,262,000 | 103% |
| SWISS REINS. CO. | 52,597,136 | 50,013,962 | 95% |
| SWISS-AM REASSURANCE CO. | 61,455,759 | 76,261,865 | 124% |
| TEACHERS INS. & ANNUITY AM. | 67,852,989 | 65,672,279 | 97% |
| TIME INSURANCE CO. | 261,727,208 | 168,438,483 | 64% |
| TRANSAMER. OCCIDENTAL LIFE | 677,325,719 | 589,344,891 | 87% |
| TRANSPORT LIFE INS. CO. | 44,188,532 | 15,890,150 | 36% |
| TRAVELERS INDEM. OF RI. | 116,064,999 | 91,124,969 | 79% |
| TRAVELERS INS. CO. | 1,817,293,817 | 1,405,793,949 | 77% |
| TRAVELERS INS. CO. OF IL. | 182,282,941 | 164,214,205 | 90% |
| TRAVERLERS INDEMNITY | 50,914,607 | 9,469,615 | 19% |
| UNION BANKERS INS. CO. | 68,866,507 | 37,703,158 | 55% |
| UNION CENTRAL LIFE INS. CO. | 81,650,946 | 63,489,602 | 78% |
| UNION LABOR LIFE | 155,591,654 | 130,467,539 | 84% |
| UNION LIFE INS. CO. | 16,348,614 | 13,324,899 | 82% |
| UNION MUTUAL LIFE INS. CO. | 101,324,628 | 79,927,962 | 79% |
| UNION NATL. LIFE INS. OF LA | 16,621,736 | 5,740,988 | 35% |
| UNIONMUTUAL STOCK LIFE AM. | 385,481,172 | 263,398,690 | 68% |
| UNIONMUTUAL STOCK LIFE NY. | 67,694,690 | 49,293,195 | 73% |
| UNITED AMERICAN INS. CO. | 216,629,860 | 94,736,773 | 44% |
| UNITED EQUITABLE INS. | 12,198,853 | 4,664,134 | 38% |
| UNITED FARM BUR. FAM. LIFE | 22,264,186 | 16,951,235 | 76% |
| UNITED FIDELITY LIFE INS. | 18,225,785 | 13,422,878 | 74% |
| UNITED FOUNDERS LIFE - OK | 10,838,264 | 6,884,699 | 64% |



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| UNITED INS. CO. OF AMERICA | 145,957,279 | 93,403,035 | 64% |
| UNITED LIFE & ACCIDENT | 20,578,024 | 12,901,878 | 63% |
| UNITED STATES LIFE INS. CO. | 128,022,102 | 99,633,207 | 78% |
| UNITED WISCONSIN INS. CO. | 21,573,000 | 16,788,819 | 78% |
| VETERANS LIFE INS. CO. | 11,527,676 | 6,353,360 | 55% |
| VULCAN LIFE INSURANCE CO. | 44,137,209 | 35,235,210 | 80% |
| WABASH LIFE INS. CO. | 11,316,909 | 6,626,654 | 59% |
| WASHINGTON NATIONAL INSURANCE | 219,780,128 | 135,323,412 | 62% |
| WESTERN LIFE INSURANCE CO. | 44,494,014 | 31,085,338 | 70% |
| WESTERN-SOUTHERN LIFE INS. | 24,858,136 | 18,073,632 | 73% |
| WINTERTHUR SWISS INS. CO. | 14,716,036 | 9,267,010 | 63% |
| WOODMEN ACCIDENT & LIFE | 44,274,070 | 32,424,217 | 73% |
| WORLD INSURANCE CO. | 24,734,991 | 14,883,396 | 60% |
| WORLD LIFE & HEALTH INS. | 11,243,961 | 5,108,198 | 45% |
| WORLD SERVICE OF COLORADO | 13,511,467 | 13,670,339 | 101% |
| ZALE LIFE INS. CO. | 11,267,808 | 6,384,109 | 57% |
| ZURICH INS. CO. | 28,799,180 | 17,295,700 | 60% |



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***designed to work in combination with Medicare by paying...***

- 100% of your Hospital Deductible
- 100% of Your Hospital Co-Payments
- 100% of all necessary hospital expenses for a lifetime maximum of 365 days after Medicare Part A hospital benefits stop completely
- Plus 20% of Medicare's allowable Doctor, Medical and Surgical expenses in or out of the hospital after you satisfy an annual $200 deductible
- Skilled Nursing Facility Benefits
- In-Hospital Private-Duty Nurse Care Benefits

| | MEDICARE CURRENTLY DOES NOT PAY | THIS PLAN CURRENTLY PAYS |
|---|---|---|
| **Hospital Costs during a benefit period:** *(Medicare Part A)* | | |
| Days 1-60 | $492.00 Deductible | $492.00 Deductible |
| Days 61-90 | $123.00 a day Co-Payment | $123.00 a day Co-Payment, for a maximum benefit of $3,690.00‡ |
| Days 91-150* | $246.00 a day Co-Payment | $246.00 a day Co-Payment, for a maximum benefit of $14,760.00‡ |
| **Total For 150 Days** | Unpaid $18,942.00‡ | Maximum Benefit Paid — $18,942.00‡ |
| **After 150 Days*** | Medicare Pays NOTHING | 100% of necessary expenses for a lifetime maximum of 365 days. |
| **Doctor, Medical & Surgical Bills:** *(Medicare Part B)* | 20% of all Medicare allowable charges...and the $75 annual Part B deductible | 20% of all Medicare allowable charges after you satisfy an annual $200 deductible**... a maximum benefit of $100,000.00 per calendar year. |
| **Skilled Nursing Facility Costs during a benefit period:** *(Medicare Part A)* | | |
| Days 1-20 | Medicare Pays All Costs | — |
| Days 21-100 | $61.50 a day Co-Payment | $61.50 a day |
| Days 101-300 | No Medicare Coverage | $61.50 a day |
| **In-Hospital Private Duty Nurse Care Costs.† Registered or Licensed Practical (Vocational) Nurse Care** | No Medicare Coverage | $30.00 per 8-hour shift† |

[redacted] Supplement 4 should not be purchased if you're eligible for Medicaid or if you already have a Medicare Supplement Insurance Plan. In addition, this plan may not be purchased if you already have a Medicare Supplement plan with Colonial Penn.

*After 90 days of hospitalization Medicare gives you an additional one-time-only Lifetime Reserve of 60 days of prescribed which may be used for days 91 to 150. Remember, once you use that, Medicare Part A hospital benefits stop completely -- BUT this supplemental prescription plans up and pays 100% of your necessary hospital expenses for a lifetime maximum of 365 days.

**This annual calendar year deductible is satisfied by the first $200 of your Medicare-allowable charges not paid by Medicare.

†Up to 3 visits per day for a maximum of 30 visits during a Medicare benefit period. The care must be prescribed by your doctor or surgeon and you must be billed directly by the nurse, not the hospital.



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| Date Prepared | 5-12-86 |
| Releasing Officer | KCC |

## Notification To Medicare Insured:

Prepared for Medicare Cardholder:

Because of ever-increasing hospital costs, the Federal Government has again increased Medicare's Hospital Deductible and Co-Payments. That's the part of YOUR hospital charges Medicare leaves for you to pay.

As a result of this, if you are hospitalized in 1986, the following higher costs under Medicare Part A may be yours to pay completely...tney are NOT paid by Medicare.

## Your Higher Out-Of-Pocket Hospital Costs:

| Days In-Hospital | 1985 Deductible & Co-Payments | 1986 Increase | 1986 Costs You Have To Pay |
|---|---|---|---|
| Days 1 through 60 | $ 400.00 | $ 92.00 | $ 492.00 |
| Days 61 through 90 | 3,000.00 | 690.00 | 3,690.00 |
| Days 91 through 150 | 12,000.00 | 2,760.00 | 14,760.00 |
| NEW TOTAL OUT-OF-POCKET COSTS | | | $ 18,942.00 |

## Immediate Action Recommended:

To protect against paying these higher out-of-pocket costs, it is recommended that you IMMEDIATELY consider adding Medicare Supplement II to your current Medicare insurance.

This added protection has been designed to work in combination with Medicare -- to help pay the costs Medicare does NOT pay...

Including all $18,942.00 listed above.

OVER, PLEASE

**Supplemental coverage that works in combination with Medicare to help pay...**

- ★ Hospital expenses
- ★ Doctor & Surgical expenses
- ★ Medical Care expenses
- ★ In-Hospital Private-Duty Nurse expenses
- ★ Skilled Nursing Facility expenses

**...expenses NOT paid by Medicare!**

**DO NOT LOSE THIS CARD**

Medicare (U) Supplement

IDENTIFICATION CARD

Hospital and Medical Insurance

227

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227

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## Details Of Coverage, Plan A

Every honorably discharged U.S. veteran has a right to cash benefits under this Hospital Insuranc

**$75.00 a day**
**$2,250.00 a month**
**Heart Attack, Stroke, Cancer Benefits Under Age 65**

You collect these increased cash benefits after the third day when hospitalization is the result of covered Heart Attack, Stroke or Cancer—even for life, if necessary!

**$50.00 a day**
**$1,500.00 a month**
**Basic Cash Benefit Under Age 65**

You collect these cash benefits for all other hospitalizations...from the very first day for every covered accident and after the third day for covered illnesses.

*In addition, this plan pays benefits for Nurse-At-Home Care, Accidental Loss Of Limbs/Sight, and DOUBLE Accident Indemnity—see Certificate of Coverage when it arrives for full details.*

*OPTIONAL COVERAGE includes: Children's and Maternity benefits. Indicate on Enrollment Form if coverage is desired.*

**Benefits for ages 65 and over are paid in addition to Medicare.**

| Days Hospitalized | You collect for covered Heart Attack/Stroke/Cancer | You collect for all other covered Accidents/Illnesses |
|---|---|---|
| 0-60 | $37.50 a day | $25.00 a day |
| 61-Lifetime | $75.00 a day | $50.00 a day |

Benefits are paid the first day of hospitalization for accidents, and after the third day for illnesses.

**The Exclusions Are:**
Prior health conditions during the first two years of coverage. Loss due to act of war; mental disease or disorder; being under the influence of alcohol or narcotics. Pregnancy, unless Optional Maternity Benefits are chosen. (Complications of pregnancy are covered as any other illness.) Certain confinements or care in facilities, as defined in your Certificate, like nursing or convalescent. The first 3 days of hospitalization due to illness.

**See LOW GROUP RATES on back ▶**

228

228

COMPANY
1986 MEDICARE SUPPLEMENT COVERAGE - POLICY FORM 911
OUTLINE OF COVERAGE

1. READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract, and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is important that you READ YOUR POLICY CAREFULLY!
2. Medicare supplement coverage -- policies of this category are designed to supplement Medicare by covering some hospital, medical, and surgical services which are partially covered by Medicare. Coverage is provided for hospital in-patient charges and some physician charges, subject to any deductibles and co-payment provisions which may be in addition to those provided by Medicare and subject to other limitations which may be set forth in the policy. The policy does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing, and taking medicine.
3. Neither Time nor its agents are connected with Medicare.
4. The following is a brief summary of the major benefit gaps in Medicare Parts A and B with a parallel description of supplemental benefits, including dollar amounts, provided by the Medicare supplement coverage.

| Service - Part A | Benefit | Medicare Pays | This Policy Pays | You Pay |
|---|---|---|---|---|
| Hospitalization - includes Semiprivate room and board, general nursing, and miscellaneous hospital services and supplies: Meals, special care units, drugs, lab tests, diagnostic x-rays, medical supplies, operating and recovery room, anesthesia, and rehabilitation services. | First 60 days | All but $492 | The $492 Deductible | Charges not eligible under Medicare |
| | 61st to 90th day | All but $123 a day | $123 daily Deductible | Charges not eligible under Medicare |
| | 90th day to 150th day | All but $246 a day | $246 daily Deductible | Charges not eligible under Medicare |
| | Beyond 150 days | Nothing | All Expense for Covered Services for Additional 365 Lifetime Maximum | All charges after 365 day Lifetime Maximum |
| Posthospital skilled nursing care in a facility approved by Medicare or a facility qualified for Medicare approval. You must have been in a hospital for at least 3 days and enter the facility within 30 days after discharge from the hospital. | First 20 days | 100% | Nothing | Charges not eligible under Medicare |
| | Additional 80 days | All but $61.50 | $61.50 per day | |
| | Beyond 100 days | Nothing | $61.50 per day for an additional 265 days | All charges less the daily amount paid by Time |
| **Service - Part B** | **Benefit** | **Medicare Pays** | **This Policy Pays** | **You Pay** |
| Medical Expenses | Physician's services, inpatient and outpatient medical services and supplies at a hospital, physical and speech therapy, and ambulance | 80% of Medicare Approved Amount (after $75 deductible) | The $75.00 Deductible and 20% of Medicare Approved Amount, then 100% of Covered Expense* after the $_____ Calendar Year Deductible. + | Anything in excess of Medicare's & Time's payments |

*Covered Expense: Means either 1) the amount charged for Medicare Part B covered service; or 2) an amount not to exceed 140% of the Medicare Approved Amount for that service, whichever is less.

+ A Calendar Year Deductible of $200.00 or $500.00 (you choose one) applies to Covered Expense which is in excess of Medicare Approved Amount. Please indicate your choice: ☐ $200.00; ☐ $500.00.

Form 17054 (Continued on Back)



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## Call 1-800

Understanding your Medicare coverage and how it works can be confusing. That's why we've installed a toll-free 800 number that gives you direct access to our Medicare Supplement Service Representatives. When you call, you'll deal with a highly trained specialist who knows the ins and outs of Medicare, as well as your Carefree Medicare Supplement policy. We're ready and willing to serve you.

## How The Medicare Supplement Policy Pays

**"Covered Services" and "Approved Amounts" For Each Benefit Period**

| Benefit | | Medicare Pays | Pays | You Pay |
|---|---|---|---|---|
| **Medicare Part A** | | | | |
| **Hospital In-Patient** | First 60 days | All but $492.00 | The $492.00 deductible* | Nothing |
| | 61st to 90th day | All but $123.00/day | The $123.00 daily deductible | Nothing |
| | 91st to 150th day | All but $246.00/day | The $246.00 daily deductible | Nothing |
| | Beyond 150 days | Nothing | All eligible expenses for additional 365 day/ lifetime maximum | Nothing |
| **Skilled Nursing** | First 20 days | 100% | Nothing | Nothing |
| | Additional 80 days | All but $61.50/day | $61.50 per day | Nothing |
| | Beyond 100 days | Nothing | $61.50 per day for an additional 265 days. | Any excess charges |
| **Blood** | First 3 pints of blood | Nothing | Full payment for first 3 pints of blood | Nothing |
| **Medicare Part B** | | | | |
| **Medical Expense** | Physician in-hospital, home or office<br>Out-patient hospital services | 80% of Medicare's "Approved Amount" after a $75 deductible | The $75 deductible and 20% of Medicare's "Approved Amount" then 100% of "Covered Expenses"** after the $200 or $500 calendar year deductible. | Either a $200 or $500 deductible; you choose. Then, any portion of the charges in excess of 140% of the Medicare "Approved Amount". |

You have no out-of-pocket expense up to Medicare's "Approved Amount".

*Coverage for the Medicare Part A deductible is optional in Georgia, Illinois and Mississippi.

**This means the expense which you incur for a Medicare Part B "Covered Service", not to exceed 140% of the Medicare "Approved Amount" for that service.

**Benefit Period:** A period that begins on the day you are admitted to a hospital and ends after a period of 60 consecutive days during which you were not confined in a hospital or Skilled Nursing Facility.



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## YOU PAY under Medicare Part A during each benefit period

- The Initial Hospital Deductible
- Extra cost of private room, unless medically necessary
- Cost of first 3 pints of blood
- Hospital Coinsurance for 61st through 90th day & 60 day Lifetime Reserve
- All hospital charges after all Medicare benefits run out
- Skilled Nursing Facility coinsurance for 21st through 100th day
- All Skilled Nursing Facility charges after the 100th day
- All charges in a Skilled Nursing Home not certified by Medicare
- All in-hospital Private Duty Nursing (R.N.) care charges

## YOU PAY under Medicare Part B each year

- Medicare's calendar year deductible
- All Medicare coinsurance (the 20% Medicare does not pay) for medical and outpatient hospital expense amounts approved by Medicare
- All medical and outpatient hospital expense in excess of amounts approved by Medicare

## YOUR MEDICARE provides these benefits during each benefit period

- The Initial Hospital Deductible 492 ^
- Extra cost of private room, if not paid by Medicare ... No Limit
- Cost of first 3 pints of blood
- Hospital Coinsurance for 61st through 90th day & 60 day Lifetime Reserve ... No Limit 123^ A Day
- All hospital charges ... No Limit 246 ^ A Day
- Medicare's Skilled Nursing Facility coinsurance for 21st through 100th day 61.50 A Day
- Medicare's daily coinsurance amount from the 101st through 365th day 61.50 A Day
- The Medicare Skilled Nursing Facility coinsurance amount for the 21st through 100th day of confinement 61.50 A Day
- Up to $30 per 8-hour shift of Private Duty Nursing (R.N.) care — limit of 2 shifts a day for 90 days

## YOUR MEDICARE provides these benefits each year

- None of the calendar year deductible (Maryland: ☐ The calendar year deductible.)
- All Medicare coinsurance (the 20% Medicare does not pay) for medical and outpatient hospital expense amounts approved by Medicare ... No Limit
- Subject to the charges not exceeding 150% of the amounts approved by Medicare, will pay (after $200 of such excess in the calendar year) 80% of excess ... No Limit

**LIMITATIONS AND EXCLUSIONS**

[redacted]

**EFFECTIVE DATE OF COVERAGE**

[redacted]

**MAKE CHECK PAYABLE TO COMPANY**

Received of _____ _____

the sum of $ _____ for _____ month's premium with application for Policy Form _____. If for any reason policy is not issued, payment is to be refunded in full. Insurance is not effective until policy applied for has been issued.

_____ _____

Date Authorized Signature

11-65

**Keep This Page — Attach It to Your Policy**

It highlights the benefits of your policy. It is not a contract. Your actual policy provisions (which may vary by state) will govern your benefits.



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**This card is the key to help pay what Medicare does NOT**

[redacted]

YOUR NAME
YOUR CERTIFICATE NO
[redacted]

[redacted]

**Everyone 65 or over needs this card**

[redacted] **PAYS**

[redacted]

- ★ 100% of your initial in-hospital deductible when you choose [redacted]
- ★ 100% of your in-hospital co-payments
- ★ 100% of your Medicare allowable expenses for one full year after Medicare stops
- ★ 100% of your co-payments for Medicare allowable doctor, medical and surgical expenses—in or out of the hospital

## Here are your [redacted] cash benefits

| MEDICARE Part A Hospital Bills | MEDICARE Does Not Pay | [redacted] (the premium plan) Pays | [redacted] (the economy plan) Pays |
|---|---|---|---|
| Day 1 through 60 | First $492.00 | First $492.00 NOT paid by Medicare | $0 |
| Days 61 through 90 | $123.00 EVERY Day | The $123.00 every day NOT paid by Medicare (Total: $3,690.00!) | The $123.00 every day NOT paid by Medicare (Total: $3,690.00!) |
| Days 91 through 150 | $246.00 EVERY Day | The $246.00 every day NOT paid by Medicare (Total: $14,760.00!) | The $246.00 every day NOT paid by Medicare (Total: $14,760.00!) |
| TOTAL at end of 150 days | $18,942.00! | The total $18,942.00 NOT paid by Medicare! | A total of $18,450.00 NOT paid by Medicare! |
| After 150 days | Medicare Stops Paying | 100% of all Medicare allowable hospital bills for one full year after Medicare stops! | 100% of all Medicare allowable hospital bills for one full year after Medicare stops! |
| Doctor, Medical, Surgical Bills (Medicare Part B) | 20% of your Medicare allowable expenses—after you pay the first $75 each year | The 20% of your Medicare allowable expenses NOT paid by Medicare—up to $100,000 a year—after you pay the first $200 of such charges. (This includes Medicare's $75 expense requirement.)** | The 20% of your Medicare allowable expenses NOT paid by Medicare—up to $100,000 a year—after you pay the first $200 of such charges. (This includes Medicare's $75 expense requirement.)** |
| OPTION Skilled nursing facility (Medicare Part A) Day 1-20*** | NOTHING UNPAID | | |
| Day 21-100 | $61.50 EVERY Day | The $61.50 every day NOT paid by Medicare (Total: $4,920.00!) | The $61.50 every day NOT paid by Medicare (Total: $4,920.00!) |

*After 90 days of Hospitalization: Medicare gives you a one-time lifetime reserve of 60 additional days of protection (Days 91-150). However, once this lifetime reserve of 60 days is exhausted, your [redacted] protection will begin paying 100%* of your Medicare allowable bills the very day Medicare ends. And you'll have a lifetime period of a full 365 additional days (one year) of protection with [redacted].

**This is the day after medical expenses not allowed by Medicare.

***Medicare pays 100%* of all reasonable costs the first 20 days of Posthospital Skilled Nursing Care in a facility approved by Medicare. You must have been hospitalized for at least 3 days and enter the facility within 30 days after hospital discharge.

Exclusions: Prior health conditions (those for which you received medical advice or treatment within the last six months) are not covered for the first six months, loss due to act of war, for care in a skilled nursing facility (if option is not selected), limited benefits for mental disorders, or for services, facilities, and unreasonable expenses not covered by Medicare. You may have only one [redacted] Medicare Supplement Insurance Plan.

- [redacted] benefits are paid direct to you or to the doctor or hospital.
- Your protection can never be canceled individually. As long as you continue your premiums and continue your Medicare coverages, and the master policy is not terminated, your protection cannot be terminated. Regardless of how much or how often you collect.
- [redacted] meets all federal standards for quality health insurance issued in Public Law 96-265.

*Your rate can increase only if rates increase for everyone in your class covered by Master Policy (NHC-1380-1083) or if your benefits are raised to match any changes in Medicare. You'll never be singled out for a rate increase, regardless of how much or how often you collect.

- Underwritten by [redacted] the insurance company nearly 2 million Americans depend on.

[redacted]

**Any Questions? Call Toll-Free**
[redacted]

Not affiliated with or endorsed by any Government or Medicare program.



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## Here's the Difference! L Medicare Supplement Policy Helps YOU Pay Costs That Medicare Doesn't Cover for BOTH Parts A and B!!

| EXPENSE INCURRED FOR | UNDER MEDICARE YOU PAY | MEDICARE PAYS | THIS MEDICARE SUPPLEMENT POLICY PAYS |
|---|---|---|---|
| **Part A: HOSPITAL (EACH COVERED HOSPITALIZATION-SEMI-PRIVATE ROOM)** | | | |
| First 60 Days | FIRST $492.00 | BALANCE | FIRST $492.00 |
| 61st through 90th Day | $123.00 PER DAY | BALANCE | $123.00 PER DAY |
| 91st to 150th Day if Lifetime Reserve Days | $246.00 PER DAY | BALANCE | $246.00 PER DAY |
| Upon exhaustion of Lifetime Reserve Days | ALL COSTS | NOTHING | 90% of Medicare Eligible Expenses for up to an additional 365 days in your lifetime |
| BLOOD BENEFIT | FIRST 3 PINTS | ALL BUT FIRST 3 PINTS | FIRST 3 PINTS |
| SKILLED NURSING FACILITY (EACH COVERED PERIOD-POST HOSPITAL) | | | |
| First 20 Days | Nothing | ALL | Nothing |
| 21st through 100th Day | $61.50 PER DAY | BALANCE | $61.50 PER DAY |
| For each day after the 100th Day | ALL COSTS | NOTHING | $123.00 a day for up to an additional 365 days in your lifetime |
| **Part B: OTHER MEDICAL EXPENSES (EACH CALENDAR YEAR)**<br>• Physician's and surgeon's services no matter where you receive them...at home, in the doctor's office, in a clinic or in a hospital. Routine physical exams are excluded.<br>• Home health visits...Medicare pays the full costs of medically necessary home health visits. You have no deductible or co-payment.<br>• Physical therapy and speech pathology services in a doctor's office or as an out-patient and on a limited basis, in your home.<br>• Other medical services and supplies... such as outpatient hospital services; X-rays and laboratory tests; certain ambulance services; and purchase or rental of durable medical equipment, such as wheel chairs. | FIRST $75.00 EACH CALENDAR YEAR - PLUS 20% OF MEDICARE ELIGIBLE CHARGES OVER $75.00, PLUS ALL EXPENSES IN EXCESS OF REASONABLE AND NECESSARY CHARGES | 80% OF REASONABLE CHARGES OVER $75.00 EACH CALENDAR YEAR (Medicare covers all medically necessary Home Health Care Visits 100% No Deductible.) | Benefits for Medicare Eligible Expenses over $75.00 at the Medicare Expense Percentage you select...your choice of a 20%, 30% or 40% Benefit for the remainder of the Calendar Year. |

**AMENDMENT RIDER 9834A**

Treatment of mental, emotional or nervous disorders shall be provided to the Insured but shall be restricted to treatment as an in-patient in a mental hospital or general hospital and shall not exceed 30 days in any policy.

This rider shall include benefits for drug and alcohol rehabilitation and treatment, whether such care be provided in a mental or general hospital or other licensed alcoholic rehabilitation facility, necessary to restore any covered person to satisfactory emotional and physical health. Alcoholic and drug rehabilitation coverage is restricted to the reasonable cost of necessary services, and ninety days of active inpatient treatment in the Covered Person's lifetime.

Expenses incurred in a Municipal, County, State or Federal controlled or operated hospital are not covered if payment is not legally required in the absence of insurance.

Neither Company nor its agents are connected with Medicare.



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## INDIVIDUAL MEDICARE SUPPLEMENT AND MEDICARE REPLACEMENT INSURANCE POLICIES

January 1, 1986 (Updated Semi Annually)
(Revised)

This list is prepared by the Insurance Commissioner's Office. It includes all individual Medicare supplement and Medicare replacement policies currently being sold in Wisconsin. Group policies such as those available through employers or associations are not included on this list.

All individual Medicare supplement policies sold in Wisconsin must fit into one of three categories. A Medicare supplement 1 is the most comprehensive. A Medicare supplement 3 is the least. A Medicare supplement 2 is in between. There is a separate category for Medicare replacements. Both Medicare supplements and Medicare replacements are explained in the booklet, "Health Insurance Advice for Senior Citizens."

Shopping around for insurance to supplement Medicare is a good idea. Check on premiums, waiting periods, and how selective the company is. This list is a good starting place. If you are interested in one of the policies on this list, contact the company directly or call a local agent for the company.

*For more information call toll-free the MEDIGAP HOTLINE at 1-800-242-1060.*

A booklet, "Health Insurance Advice for Senior Citizens" is available by sending a stamped, self-addressed envelope to:

Office of the Commissioner of Insurance
P.O. Box 7873
Madison WI 53707-7873

**BE CAREFUL ABOUT REPLACING EXISTING POLICIES. THERE MAY BE NEW WAITING PERIODS OR OTHER RESTRICTIONS PLACED ON YOUR BENEFITS.**

| | 1986 Annual Premium (subject to change) | Eligibility Standards* | Waiting Period** for Pre-existing Conditions | 1st Year Commission to Agent | Brief Description of Benefits*** Medicare Part A | Medicare Part B |
|---|---|---|---|---|---|---|
| **MEDICARE SUPPLEMENT 1** | | | | | | |
| Bankers Life and Casualty Company<br>4444 West Lawrence Ave.<br>Chicago IL 60630<br>Form No. CR-97F | | No health questions asked | 60 days | 26% to age 75<br>13% after age 75 | *Hospital* - After initial deductible, policy pays co-insurance. After 100 days, pays 100%<br><br>*Skilled Nursing Facility*<br>Co-insurance to 100th day. 100% of charges to 365 days, $50.00 per day for another 100 days | *Medical* - After $75 deductible, policy pays difference between Medicare's payment and the usual and customary charges as determined by the company to $10,000 per year.<br><br>*Other benefits* - 75% of the usual and customary expense for prescription drugs; subject to the $10,000 per year Medicare Part B coverage limit |
| Age: | | Age: | | | | |
| 65 | $ 843.59 | 71 | $1,174.46 | | | |
| 66 | 890.07 | 72 | 1,124.23 | | | |
| 67 | 940.57 | 73 | 1,311.15 | | | |
| 68 | 933.81 | 74 | 1,384.35 | | | |
| 69 | 1,050.97 | 75+ | 1,472.93 | | | |
| 70 | 1,111.19 | | | | | |
| Non-Smokers discount available. Additional benefits available at additional cost. | | | | | | |

| MEDICARE SUPPLEMENT 2 | 1986 Annual Premium (subject to change) | Eligibility Standards* | Waiting Period** for Pre-existing Conditions | 1st Year Commission to Agent | Brief Description of Benefits*** Medicare Part A | Medicare Part B |
|---|---|---|---|---|---|---|
| Aid Association for Lutherans<br>4321 North Ballard Road<br>Appleton WI 54919<br>Form No. 4717WI<br>Area (first 3 digits of zip code)<br>530, 531, 534<br>532<br>535, 546, 549,<br>537, 539, 544, 545<br>538, 540, 543, 547, 548 | Male / Female<br>$699.28 / $667.11<br>710.56 / 678.27<br>680.49 / 648.51<br>661.68 / 629.91<br>635.36 / 603.87 | Health questions asked<br>Available only to Lutherans | 6 months | 15% | *Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays 100%<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day. 100% of charges to 365th day | *Medical* - After $75 deductible, policy pays 25% of charges incurred.<br>*Other benefits* - Pays 100% of prescription drugs and 30% of private duty nursing expenses after $60 annual deductible |
| American Family Mutual Ins. Co.<br>3099 East Washington Avenue<br>P.O. Box 7430<br>Madison WI 53783<br>Form No. H-65<br>Age 65<br>70<br>75<br>80<br>85<br>This is a summary of premiums. There is a different premium for each age. | All Zip Codes except Madison and Milwaukee: Male / Female<br>$446.50 / $404.70<br>499.70 / 449.40<br>588.10 / 526.30<br>687.80 / 609.90<br>768.60 / 700.20<br>Madison and Milwaukee: Male / Female<br>$470.00 / $426.00<br>526.00 / 473.00<br>619.00 / 554.00<br>724.00 / 642.00<br>809.00 / 737.00 | Health questions asked | 6 months | 16.75% | *Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays all eligible expenses to 365 days<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day 100% to 365th day | *Medical* - Policy pays $75 deductible if you are hospitalized plus 20% Medicare approved charges |
| American Republic Insurance Company<br>P. O. Box 1<br>Des Moines IA 50334<br>Form No. A-2400WI 5-85<br>Age:<br>65-69<br>70-74<br>75-80<br>Additional benefits available at additional cost | $447.18<br>505.74<br>567.74 | Health questions asked | 6 months | 40% | *Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays all eligible expenses to 365 days lifetime maximum.<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day 100% to 365 days per benefit period | *Medical* - After $75 deductible, policy pays 20% of Medicare-approved charges up to $100,000. |



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| MEDICARE SUPPLEMENT 2 | 1986 Annual Premium (subject to change) | Eligibility Standards* | Waiting Period** for Pre-existing Conditions | 1st Year Commission to Agent | Brief Description of Benefits*** Medicare Part A | Medicare Part B |
|---|---|---|---|---|---|---|
| Benefit Trust Life<br>1771 Howard Street<br>Chicago IL 60626<br>Form No. MSW182 | Age:<br>65 $ 667.23<br>66-69 765.35<br>70-74 913.43<br>75-79 1,098.99<br>80-84 1,323.78<br>85+ 1,578.88 | General questions on confinement in hospital or other facility, current treatment for cancer, kidney, dialysis and mental illness | 45 days | 45% average | *Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays up to 525th day<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day. Usual and customary charges to 365th day | *Medical* - After $75 deductible, policy pays 20% of usual and customary charges up to $100,000 per year<br>*Other benefits* - 80% of prescription drug charges after hospital confinement and 80% of private duty nursing charges for 14 days in hospital and 14 days following hospital confinement |
| Blue Cross & Blue Shield United of Wisconsin<br>401 W. Michigan Street<br>Milwaukee WI 53202<br>Form No. X-1425a | $479.40 (same for everybody) | General questions on confinement in hospital or other facility and ability to perform normal activities | 6 months | 10% | *Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays next 365 in full<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day. 100% to 365 days | *Medical* - Policy pays $75 and 20% of Medicare-approved charges up to $5,000 |
| | | | | | After $500 out-of-pocket, pays up to $250,000 for Major Medical hospital, medical expense and prescription drug benefits. | |
| Central States Health & Life Co. of Omaha<br>96th and Western<br>Omaha NE 68134<br>Form No. 286 WI Rev.<br><br>Additional benefits available at additional cost. | Age:<br>65-69 $408.00<br>70-74 474.00<br>75+ 576.00 | Health questions asked | None | 40% | *Hospital* - After initial deductible, policy pays co-insurance to 150th day. After 150 days pays up to 365 days<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day. 100% to 365 days | *Medical* - After $75 deductible, policy pays 20% of usual and customary charges as determined by the company |

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(234)

| MEDICARE SUPPLEMENT 2 | 1986 Annual Premium (subject to change) | Eligibility Standards* | Waiting Period** for Pre-existing Conditions | 1st Year Commission to Agent | Brief Description of Benefits*** Medicare Part A | Medicare Part B |
|---|---|---|---|---|---|---|
| Compcare Health Services Insurance Corp.*<br>401 West Michigan Street<br>Milwaukee WI 53201<br>Form No. PGP-660<br>Available in Racine and Burlington areas only | $691.80 for everybody | Health questions asked | None | Independent agent -- 10%<br>Company agent -- $.50 per month for duration of policy | *Hospital* - After initial deductible, policy pays co-insurance. After 150 days, policy pays for unlimited number of days<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day 100% to 365 days per benefit period | *Medical* - After $75 deductible, policy pays 20% of Medicare-approved charges and 20% of usual and customary charges for non-Medicare covered charges as determined by the company. |
| Compcare Health Services Insurance Corp.*<br>401 West Michigan<br>Milwaukee WI 53201<br>Form No. PGP-661<br>Available in Racine and Burlington areas only | $598.20 for everybody | No health questions asked | None | Independent agent -- 10%<br>Company agent -- $.50 per insured per month for duration of policy | *Hospital* - After initial deductible, policy pays co-insurance to 150th day. 100% for unlimited number of days<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day<br>After 100th day, pays additional benefits for 265 days | *Medical* - After initial deductible, policy pays 20% of Medicare approved charges and 20% of usual and customary charges for non-Medicare covered charges as determined by the company |
| Continental Casualty Company<br>CNA Plaza<br>Chicago IL 60685<br>Form No.. P1-67720-B48<br>Age: 65-69 $ 596.27 $ 533.17<br>70-74 741.49 637.92<br>75-79 914.07 785.07<br>80-84 1,045.34 923.50<br>85+ 1,216.17 1,073.03<br>Additional benefits available at additional cost. | Male / Female | General questions on confinement in hospital, skilled nursing facility or rehabilitation facility in last 60 days | 3 months | 42% average | *Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays next 365 in full<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day. 100% to 365 days | *Medical* - Policy pays $75 deductible and 20% or 40% of Medicare-approved charges |

*This is a Medicare supplement health maintenance organization. Full benefits generally are paid only if services are received from participating providers in the geographical area served by the plan.

(235)

30b (Rev. 01/86)

Page 4

237

237

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| MEDICARE SUPPLEMENT 2 | 1986 Annual Premium (subject to change) | Eligibility Standards* | Waiting Period** for Pre-existing Conditions | 1st Year Commission to Agent | Brief Description of Benefits*** Medicare Part A | Medicare Part B |
|---|---|---|---|---|---|---|
| Continental General Insurance Company<br>8901 Indian Hills Drive<br>Omaha NE 68114<br>Form 318<br>Age: 65 $419.40<br>70 505.00<br>75 598.50<br>80 683.50<br>85+ 798.30<br>Additional benefits available at additional cost. | Limited health questions asked | 60 days | 60% | *Hospital* - After initial deductible, policy pays co-insurance. After 150th day, pays 100% to 365 days. Rider to cover initial deductible available at additional cost<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day. 100% to 365 days per benefit period | *Medical* - Policy pays $75 deductible and 20% of usual and customary charges as determined by the company<br>*Other Benefits* - Policy pays initial Part A deductible. Policy pays 40% usual and customary charges of Part B benefits (Policy pays nothing for the Part B initial deductible and hospital indemnity benefits) |
| Dean Health Plan, Inc.* $438 (for everybody)<br>1313 Fish Hatchery Road<br>Madison WI 53715<br>Form No. 1059-0484<br><br>Available in Columbia, Dane, Dodge, Fond du Lac, Green, Green Lake, Iowa, Jefferson, Juneau, Lafayette, Marquette, Richland, Rock, Sauk and Walworth counties only | No health questions asked | None | None-agents are salaried | *Hospital* - Policy pays initial deductible, and co-insurance to 150th day. 100% after 150th day<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day. 100% after | *Medical* - Policy pays $75 deductible and 20% of Medicare-approved charges. |
| Federal Life Insurance Company<br>3750 West Deerfield Road<br>Riverwoods IL 60015<br>A-7400 WISC<br>Age: 65-69 $281.49<br>70-74 321.45<br>75-79 344.99<br>80-84 359.07<br>85+ 372.95<br>Additional benefits available at additional cost | Limited health questions asked | 6 months | 40% | *Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays next 365 days in full. Rider to cover initial deductible available at additional cost<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day 100% to 365 days | *Medical* - Policy pays $75 deductible and 20% of Medicare-approved charges up to $20,000 |

*This is a Medicare supplement health maintenance organization. Full benefits generally are paid only if services are received from participating providers in the geographical area served by the plan.

(236)



238

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| MEDICARE SUPPLEMENT 2 | 1986 Annual Premium (subject to change) | Eligibility Standards* | Waiting Period** for Pre-existing Conditions | 1st Year Commission to Agent | Brief Description of Benefits*** Medicare Part A | Medicare Part B |
|---|---|---|---|---|---|---|
| Federal Home Life Insurance Company<br>78 West Michigan Mall<br>Battle Creek MI 49017<br>Form No. 4535(8) WI<br>Age: 65-69 $ 672.69 $ 584.25<br>70-74 785.77 685.89<br>75-79 904.57 809.53<br>80-84 1,051.09 962.21<br>85+ 1,188.37 1,095.97<br>Additional benefits available at additional cost | 20% Option<br>Male Female | Health questions asked | 6 months | 50% | *Hospital* - Policy pays initial deductible and co-insurance to 150th day. After 150 days, pays next 365 days in full<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day. 100% to 365 days | *Medical* - After you pay $75 deductible, policy pays 20% of usual and customary charges as determined by the company |
| Greater Marshfield Community* Health Plan<br>Blue Cross & Blue Shield United of WI<br>401 W. Michigan Street<br>Milwaukee WI 53202<br>Form No. PGP-631<br>Available in Barron, Chippewa, Clark, Eau Claire, Jackson, Marathon, Price, Rusk, Taylor, Washburn and Wood Counties | $630.00 | None - Must live in Greater Marshfield area 9 months per year. Enrollment at age 65 only | None | 3% | *Hospital* - Policy pays deductible and co-insurance and unlimited hospital days<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day. 100% for unlimited days if needed for treatment and requested by doctor | *Medical* - Policy pays $75 deductible and 20% of usual and customary charges as determined by the company. |
| Group Health Cooperative of Eau Claire*<br>1010 West Clairemont Avenue<br>Eau Claire WI 54701<br>Form No. 5000<br>Age: 65-74 $300<br>75+ 420<br>Note: Only Quarterly Premiums Accepted<br>Additional benefits available at additional cost | | Health questions asked | None | None - there are no agents | *Hospital* - Policy pays deductible, and co-insurance. After 150 days, pays 100% to 365 days lifetime maximum<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day 100% to 365 days | *Medical* - Policy pays $75 deductible, and 100% of difference between Medicare-approved and actual charges |

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239

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| 1986 Annual Premium (subject to change) | Eligibility Standards* | Waiting Period** for Pre-existing Conditions | 1st Year Commission to Agent | Brief Description of Benefits*** Medicare Part A | Medicare Part B |
|---|---|---|---|---|---|
| **MEDICARE SUPPLEMENT 2** | | | | | |
| Guarantee Trust Life Ins. Co.<br>2537 W. Montrose Avenue<br>Chicago IL 60618<br>Form No. 25916-2<br>Age:<br>65-69 $ 739.30<br>70-74 816.32<br>75-79 894.10<br>80-84 963.50<br>85+ 1,042.92 | Health questions asked | 6 months | 60% | *Hospital* - After initial deductible, policy pays co-insurance to 150th day. After 150th day, pays 100% to 365 day lifetime maximum. Rider to cover initial deductible available at additional cost<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day. 100% of Medicare allowable charges to 365th day. | *Medical* - Policy pays $75 deductible and 20% of Medicare-approved charges. |
| HMO of Wisconsin*<br>180 Washington Street<br>Prairie du Sac WI 53578<br>Form No. 12-040-0285<br>$483.84 (For ever/body)<br><br>Available in Columbia, Dane, Green, Jefferson, Rock and Sauk Counties only | Health questions asked | None | None | *Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays 100% up to 365 days<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day. 100% to maximum of 365 days per benefit period | *Medical* - Policy pays $75 deductible and 20% of usual and customary charges up to $5,000 per year. |
| Jackson Health Plan*<br>345 West Washington Avenue<br>Madison WI 53703<br>Form No. XXX-291<br>Age:<br>65-69 $356.64<br>70-74 409.56<br>75-79 491.16<br>80+ 568.08<br><br>Available in Columbia, Dane, Green, Jefferson, Rock and Sauk Counties only | Health questions asked | None | None | *Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays 100% up to a maximum of 365 days in a lifetime<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day. 100% to 365 days | *Medical* - Policy pays $75 deductible and 100% of remaining charges for services provided by plan providers. |

*This is a Medicare supplement health maintenance organization. Full benefits generally are paid only if services are received from participating providers in the geographical area served by the plan.

(238)

| MEDICARE SUPPLEMENT 2 | 1986 Annual Premium (subject to change) | Eligibility Standards* | Waiting Period** for Pre-existing Conditions | 1st Year Commission to Agent | Brief Description of Benefits*** Medicare Part A | Medicare Part B |
|---|---|---|---|---|---|---|
| Medical Associates Clinic Health Plan of Wisconsin* One Dubuque Plaza Dubuque IA 52001 Form No. Med-Con. WI. Available in Crawford and Grant Counties | $468.00 for everybody | No health questions asked | None | None | *Hospital* - After initial deductible, policy pays co-insurance. After 150th day, pays 100% *Skilled Nursing Facility* Co-insurance to 100th day 100% after 100th day | *Medical* - After $75 deductible, policy pays 100% of difference between Medicare-approved and actual charges. *Other Benefits* - 50% of out of hospital psychiatric coverage per calendar year |
| Medico Life Insurance Company/ Mutual Protective Insurance Company 4625 Farnam Street Omaha NE 68132 Form No. ML435ZL/MP 48ZL Age: 64 1/2-69 $ 699.60; 70-74 832.00; 75-79 872.95; 80 & over 1,047.25 Additional benefits available at additional costs | | Health questions asked | 6 months | 55% | *Hospital* - After intitial deductible, policy pays co-insurance to 150th day. After 150 days, 100% of Medicare allowable charges to 365th day *Skilled Nursing Facility* Co-insurance to 100th day 100% to 365 days per benefit period | *Medical* - After initial deductible, policy pays 20% of Medicare-approved charges up to $20,000 in a calendar year |
| MidAmerica Mutual Life Hennepin Square 2021 E. Hennepin Avenue Minneapolis MN 55413 Form No. U-1086WI Age: 65-69 $444.00; 70-74 449.50; 75 & older 555.00 | | Health questions asked | 6 months | 25% | *Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays 100% of costs to lifetime maximum of 365 days *Skilled Nursing Facility* Co-insurance to 100th day. An additional 265 days per benefit period paying 100% of the cost | *Medical* - Policy pays $75 deductible and 20% of Medicare approved charges up to $5,000 each calendar year |

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(239)

30b (Rev. 01/86)

Page 8

241

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| | 1986 Annual Premium (subject to change) | Eligibility Standards* | Waiting Period** for Pre-existing Conditions | 1st Year Commission to Agent | Brief Description of Benefits*** | |
|---|---|---|---|---|---|---|
| | | | | | Medicare Part A | Medicare Part B |
| **MEDICARE SUPPLEMENT 2** | | | | | | |
| Midelfort Clinic*<br>1119 Regis Court<br>Eau Claire WI 54701<br>Form No. XXX-291<br>Available in Barron, Buffalo, Chippewa, Dunn, Eau Claire, Pierce, Pepin, Polk, Rusk, St. Croix, Trempealeau and Washburn Counties only | Age:<br>65-69 $432.00<br>70-74 496.80<br>75-79 595.20<br>80+ 688.20 | Health questions asked | None | None | *Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays 100% up to a maximum of 365 days in a lifetime<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day.<br>100% to 365 days | *Medical* - Policy pays $75 deductible and 100% of remaining charges. |
| Mutual of Omaha<br>Mutual of Omaha Plaza<br>Omaha NE 68175<br>Form No. M40 | Age:<br>65-69 $490.68<br>70-74 604.32<br>75-79 662.28<br>80+ 726.48 | Health questions asked | 6 months on ridered conditions | 37% | *Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays 100% up to 365 days in a lifetime<br>*Skilled Nursing Facility Approved by Medicare*<br>Co-insurance to 100th day.<br>100% to 365 days<br>*Skilled Nursing Facility Not Approved by Medicare*<br>Policy pays 100 days at the daily rate established for such skilled nursing home by the Wisconsin Department of Health and Social Services | *Medical* - After you pay $75 deductible, policy pays 30% of Medicare-approved charges. $75 deductible paid if hospital-confined |

*This is a Medicare supplement health maintenance organization. Full benefits generally are paid only if services are received from participating providers in the geographical area served by the plan.

242

(240)

| MEDICARE SUPPLEMENT 2 | 1986 Annual Premium (Show change) | Eligibility Standards* | Waiting Period** for Pre-existing Conditions | 1st Year Commission to Agent | Brief Description of Benefits*** Medicare Part A | Medicare Part B |
|---|---|---|---|---|---|---|
| National States Ins. Co.<br>11433 Olde Cabin Rd.<br>St. Louis MO 63141 Age:<br>Form No. SMA-2 to 70 $524.00<br>71-75 641.00<br>76+ 735.00<br>Additional benefits available at additional cost | | Health questions asked | 6 months | 60% | *Hospital* - Policy pays full deductible and co-insurance. After 15 days, pays 100% of expenses for next 365 days<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day - 100% to 365th day | *Medical* - Policy pays $75 deductible and 20% of Medicare-approved charges up to $5,000 maximum per calendar year |
| Pekin Life<br>2505 Court Street<br>Pekin IL 61558 Age:<br>Form No. M15 (W) 65-69 $258.20<br>70-74 300.42<br>75-79 347.31<br>80-84 387.77<br>85+ 427.18<br>Additional benefits available at additional cost | | Limited health questions asked | 6 months | 20% | *Hospital* - After initial deductible, policy pays co-insurance. After 150 days policy pays 100% of Medicare-eligible expenses to 365 days<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day. 100% Medicare-eligible expenses to 365 days | *Medical* - After you pay $75 deductible, policy pays 20% of Medicare-approved charges |
| Physicians Mutual Insurance Company 20%<br>115 S. 42nd Street Age: 65-69 $486.43<br>Omaha NE 68131 70-79 614.61<br>Form No. P192K-0783 80-89 785.12<br>Additional benefits available at additional cost | | A general question on confinement in hospital or nursing home in past 90 days | None | 20% | *Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays next 365 in full<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day. 100% to 365 days | *Medical* - After $60 deductible, policy pays 20% or 40% of actual charge if Medicare pays part of that charge |
| Rural Security Life Insurance Company<br>7010 Mineral Point Road<br>Madison WI 53705<br>Form No. HP-112 (7-82)<br>Male $763.11<br>Female 566.21 | | Health questions asked | None | 8% | *Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays next 365 in full<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day. 100% to 365 days. | *Medical* - Policy pays $75 deductible and all eligible expenses not paid by Medicare to maximum of $10,000. Not limited to Medicare's approved charge |

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| 1986 Annual Premium (subject to change) | Eligibility Standards* | Waiting Period** for Pre-existing Conditions | 1st Year Commission to Agent | Brief Description of Benefits*** Medicare Part A | Medicare Part B |
|---|---|---|---|---|---|
| **MEDICARE SUPPLEMENT 2** | | | | | |
| State Farm Mutual Automobile Ins. Co.<br>One State Farm Plaza<br>Bloomington IL 61701 Age:<br>Form No. 97033MA 0-64 $572.30<br>65-69 360.90<br>70-74 449.70<br>75+ 540.40<br>Available to people under age 65 who are on Medicare because of a disability and are converting from company's hospital-surgical policy | No health questions asked | 6 months | 17% | *Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays Medicare-approved expenses up to 365 days.<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day. After 100 days, eligible expenses to extent not covered by Medicare to 365 day maximum | *Medical* - Policy pays $75 deductible and 20% of Medicare-approved charges, up to $5,000 per year |
| Time Insurance Company<br>515 West Wells Street<br>Milwaukee WI 53201 Male Female<br>Form No. 913 Age: 65-69 $742.00 $714.00<br>70-74 822.00 799.00<br>75-79 879.00 856.00<br>80-84 907.00 896.00<br>85+ 919.00 921.00<br>Additional benefits available at additional cost | Health questions asked | 6 months | 30% | *Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays next 265 in full<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day. 100% to 365 days | *Medical* - After you pay $75 deductible, policy pays 20% of Medicare-approved charge. After either $200 or $500 of eligible expenses in excess of approved amount, policy pays 100% up to 140% of Medicare |
| Wisconsin Physicians Service $369.00<br>1717 West Broadway (same for<br>Madison WI 53708 everybody)<br>Form No. 13789-B51-8207 | Open enrollment at age 65; health questions asked at other times | 6 months | 15% | *Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays all hospitalization in full<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day. 100% after 100th day | *Medical* - Policy pays $75 deductible and 20% of Medicare-approved charges up to $5,000 per year |

| MEDICARE SUPPLEMENT 3 | 1986 Annual Premium (subject to change) | Eligibility Standards* | Waiting Period** for Pre-existing Conditions | 1st Year Commission to Agent | Brief Description of Benefits*** Medicare Part A | Medicare Part B |
|---|---|---|---|---|---|---|
| American Income Life Ins. Co.<br>P.O. Box 208<br>Waco TX 76797<br>Form No. M41004 | Age: 65-69 $563.00; 70-74 625.00; 75-79 683.00; 80-84 720.00; 85+ 732.00 | Health questions asked | 6 months | 50% | *Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays 90% to 365 days<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day | *Medical* - Policy pays $75 deductible and 20% of Medicare-approved charges |
| Bankers Life and Casualty Co.<br>4444 Lawrence Avenue<br>Chicago IL 60630<br>Form No. GR-75R<br>Age: 65 $354.76; 66 371.02; 67 389.78; 68 410.29; 69 432.65; 70 456.76; 71 $482.72; 72 510.43; 73 540.10; 74 571.52; 75 605.12<br>Lower rates for non-smokers. Additional benefits available at additional cost | | No health questions asked | 60 days | 26% to age 75<br>13% after age 75 | *Hospital* - After initial deductible, policy pays full deductible and co-insurance. After 150 days, pays 100% of usual and customary expenses.<br>*Skilled Nursing Facility*<br>Nothing | *Medical* - After you pay $75 deductible, policy pays 20% of Medicare-approved charges up to $5,000 maximum each year |
| Bankers Life and Casualty Co.<br>4444 Lawrence Avenue<br>Chicago IL 60630<br>Form No. GR-75D (1982) | Age: 65-69 $446.90; 70-74 689.45; 75+ 774.54 | No health questions asked | 60 days | 25% | *Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays 100% of usual and customary expenses.<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day | *Medical* - After you pay $75 deductible, policy pays 20% of Medicare-approved charges up to a $5,000 maximum each calendar year |
| Benefit Trust Life<br>1771 W. Howard Street<br>Chicago IL 60626<br>Form No. MSP 182 WI | Age: 65 $ 606.58; 66-69 695.77; 70-74 829.59; 75-79 959.07; 80-84 1,204.25; 85+ 1,436.17 | Health questions on confinement in hospital or other facility, current treatment for cancer, kidney dialysis and mental illness | 45 days | 45% average | *Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays 90% up to 525th day<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day. 80% of usual and customary up to 180th day | *Medical* - After you pay $75 deductible, policy pays 20% of usual and customary charges up to $100,000 per year.<br>*Other benefits* - 80% of prescription drug charges after hospital confinement and 80% of private duty nursing charges for 14 days in hospital and 14 days after hospital confinement |

30b (Rev. 1/86)



245

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| 1986 Annual Premium (subject to change) | Eligibility Standards* | Waiting Period** for Pre-existing Conditions | 1st Year Commission to Agent | Brief Description of Benefits*** Medicare Part A | Medicare Part B |
|---|---|---|---|---|---|
| **MEDICARE SUPPLEMENT 3** | | | | | |
| Globe Life and Accident Insurance Company<br>Globe Life Center<br>Oklahoma City OK 73184<br>Form No. MCF-3HWI<br><br>Age: 65-70 $563.00<br>71-75 652.00<br>76-85 744.00<br>86-90 835.00<br>Additional benefits available at additional cost | Health questions asked | 6 months | 40% | *Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays 100 to 365 days<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day. Nothing after that | *Medical* - After you pay $75 deductible, policy pays either 20% or 32% of Medicare-approved charges |
| Guarantee Trust Life Ins. Co.<br>2537 W. Montrose Avenue<br>Chicago IL 60618 Age:<br>Form No. 80335-3C 65-69 $323.20<br>70-74 351.90<br>75-79 375.60<br>80-84 393.40<br>85+ 416.20<br><br>Additional benefits available at additional cost | Health questions asked | 6 months | 60% | *Hospital* - After initial deductible, policy pays full deductible and co-insurance. After 150 days, pays next 365 days at 90%<br>*Skilled Nursing Facility*<br>Nothing | *Medical* - After $200 deductible, policy pays 20% of the remaining eligible expenses up to $5,000 a year. |
| Lutheran Brotherhood<br>625 4th Ave. S<br>Minneapolis MN 55415 (Zip Code: 538-549)<br>Form No. H1-MS-1WI (First three digits)<br>Age: 65 $383.00 Age: 69 $423.00<br>66 392.00 70-74 454.00<br>67 404.00 75-79 502.00<br>68 414.00 80-84 543.00<br>(Higher in other zip code areas)<br>Additional benefits available at additional cost | Health questions asked<br><br>(Available only to Lutherans) | 6 months | 15% | *Hospital* - After initial deductible, policy pays co-insurance. After 150 days, pays 100% of costs<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day. Nothing after that | *Medical* - After you pay $75 deductible, policy pays 30% of usual and customary charges as determined by company |

| MEDICARE SUPPLEMENT 3 | 1986 Annual Premium (subject to change) | Eligibility Standards* | Waiting Period** for Pre-existing Conditions | 1st Year Commission to Agent | Brief Description of Benefits*** Medicare Part A | Medicare Part B |
|---|---|---|---|---|---|---|
| Medico Life Insurance/<br>Mutual Protective Insurance Company<br>4625 Farnam St.<br>Omaha NE 68132<br>Form No. ML4085 YL/<br>MP-485YL<br>Additional benefits available at additional costs | Age:64½-69 $651.10<br>70-74 775.80<br>75-79 814.00<br>80+ 975.75 | Health questions asked for 40% and 60% plans | 6 months | 55% | *Hospital* - Policy pays full deductible and co-insurance. After 150 days, policy pays 100% of Medicare covered charges<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day. Nothing after that | *Medical* - Policy pays $75 deductible and 20% of Medicare-approved charges up to $20,000 in a calender year |
| Medico Life Insurance/<br>Mutual Protective Insurance Company<br>4625 Farnam St.<br>Omaha NE 68132<br>Form No. ML4085/<br>MP 4085<br>Additional benefits available at additional costs | Age:64½-69 $152.80<br>70-79 219.50<br>80+ 290.55 | No health questions asked unless rider applied for | 6 months | 55% | *Hospital* - After initial deductible, policy pays co-insurance. After 150 days, policy pays 100% of Medicare-eligible expenses<br>*Skilled Nursing Facility*<br>Nothing | *Medical* - After you pay $200 deductible, policy pays 20% of Medicare-approved charges up to $20,000 a year |
| Mutual of Omaha Insurance Company<br>3301 Dodge Street<br>Omaha NE 68131<br>Form No. MD12 $462.60 | | General questions on confinement in hospital and other insurance coverage | 6 months | None | *Hospital* - After initial deductible, pays co-insurance to 150th day. After 150 days, 90% of hospital for 365 days maximum lifetime<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day. After 100th day, $20.00 a day for 100 days per benefit period | *Medical* - Policy pays $75 deductible and after an initial deductible of $200 of allowable charges, pays 20% of Medicare-approved charges<br>*Other Benefits* - Policy pays coverage for spouse |

247

(245)

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| | 1986 Annual Premium (subject to change) | Eligibility Standards* | Waiting Period** for Pre-existing Conditions | 1st Year Commission to Agent | Brief Description of Benefits*** Medicare Part A | Medicare Part B |
|---|---|---|---|---|---|---|
| **MEDICARE SUPPLEMENT 3** | | | | | | |
| Mutual of Omaha<br>Mutual of Omaha Plaza<br>Omaha NE 68175<br>Form No. M38 | Age:<br>65-69 $393.36<br>70-74 483.12<br>75-79 528.96<br>80+ 579.60 | Health questions asked | 6 months on ridered conditions | 20% | *Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays 90% up to 365 days in lifetime<br>*Skilled Nursing Facility Approved by Medicare*<br>Co-insurance to 100th day. Next 100 days, $20 a day<br>*Skilled Nursing Facility Not Approved by Medicare*<br>Policy pays 30 days at the daily rate established for such nursing homes by the Wisconsin Department of Health and Social Services | *Medical* - After you pay $75 deductible, policy pays 20% of Medicare-approved charges |
| National Casualty Company<br>P. O. Box 463<br>Southfield MI 48037<br>Form No. 8427 MUL<br>Age: 65-69 $567 $444<br>70-74 667 555<br>75-79 764 634<br>80+ 852 701<br>Additional benefits at extra costs | Male Female | Health questions asked | 6 months | 59% | *Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays 90% of costs to a lifetime maximum of 365 days<br>*Skilled Nursing Facility*<br>Co-insurance up to 150 days. After 150th day, $100 a day up to 365 days in a lifetime | *Medical* - After you pay $75 deductible, policy pays 20% of Medicare-approved charge |
| National States Insurance Co.<br>11433 Olde Cabin Rd<br>St. Louis MO 63141<br>Form No. SNS-3<br>Additional benefits available at additional cost | Age:<br>to 70 $388.00<br>71-75 449.00<br>76+ 514.00 | Health questions asked | 3 months | 60% | *Hospital* - Policy pays full deductible and co-insurance. After 150 days, pays next 365 days at 90%.<br>*Skilled Nursing Facility*<br>Co-insurance to 50th day. Nothing after that | *Medical* - After $75 deductible, policy pays 20% of usual and customary charges up to $5,000 in a calendar year |

(246)

| MEDICARE SUPPLEMENT 3 | 1986 Annual Premium (subject to change) | Eligibility Standards* | Waiting Period** for Pre-existing Conditions | 1st Year Commission to Agent | Brief Description of Benefits*** Medicare Part A | Medicare Part B |
|---|---|---|---|---|---|---|
| National Travelers Life Co.<br>820 Keosauqua Way<br>Des Moines IA 50308<br>Form No. MP6160 WI 4-83 | Age:<br>65 $564.00<br>66 598.00<br>67 635.00<br>68 672.00<br>69 717.00<br>70+ 775.00 | Health questions asked | 6 months | 35% | *Hospital* - Policy pays full deductible and co-insurance. After 150th day, policy pays 100% of eligible expenses to 365th day<br>*Skilled Nursing Facility*<br>Policy pays co-insurance to 100th day, pays $75 a day for 265 days in a benefit-period | *Medical* - After $75 deductible, policy pays 40% of reasonable charges up to $5,000 maximum per year |
| New York Life Ins. Co.<br>51 Madison Avenue<br>New York NY 10010<br>Form No. 8145-8<br>Individual / Family Basis<br>Age: Male / Female / Male / Female<br>65-69 $528.00 / $488.40 / $508.20 / $468.60<br>70-74 613.80 / 567.60 / 594.00 / 554.40<br>75-79 686.40 / 627.60 / 660.00 / 613.80<br>80-84 732.60 / 693.00 / 719.40 / 679.80 | | No health questions asked | 6 months | 30% | *Hospital* - Policy pays full deductible and co-insurance. After 150 days, policy pays reasonable charges up to 365 days<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day | *Medical* - After $75 deductible, policy pays 20% of Medicare-approved charges or reasonable charges as determined by company, whichever is greater |
| Union Labor Life Insurance Co<br>111 Massachusetts Ave., NW<br>Washington DC 20001<br>Form No. Ind. A.H. 5093-83<br>Age: 20%<br>65-74 $574.00<br>75% 815.00<br>30% and 40% Part B options available at additional cost | | General questions on current confinement in hospital or nursing home | 6 months | 40% | *Hospital* - Policy pays full deductible and co-insurance. After 150 days, policy pays 90% of expenses up to 365 days<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day. | *Medical* - Policy pays $75 deductible plus 20% of Medicare-eligible charges up to maximum benefit of $5,000 |

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| | 1986 Annual Premium (subject to change) | Eligibility Standards* | Waiting Period** for Pre-existing Conditions | 1st Year Commission to Agent | Brief Description of Benefits*** Medicare Part A | Medicare Part B |
|---|---|---|---|---|---|---|
| MEDICARE SUPPLEMENT 3 | | | | | | |
| United American Ins. Co.<br>2909 W. Buchner Blvd.<br>Dallas TX 75221<br>Form MAXC (48) | $770 (for everyone) | Health questions asked | 60 days | 60% | *Hospital* - Policy pays initial deductible and co-insurance. After 150 days, pays 100% of expense.<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day. After 100th day, pays $38 a day for 265 days | *Medical* - After $75 deductible, policy pays 20% of allowable charge. After first $200 of Medicare-eligible expense in excess of Medicare approved amount, 80% of each subsequent item of excess but not to exceed 50% of amount approved by Medicare for item |
| United American Ins. Co.<br>2909 W. Buckner Blvd.<br>Dallas TX 75221<br>Form DMXC (48) | $572 for everyone 64 and over $737 for everyone under 65 and on disability | Health questions asked | 6 months | 60% | *Hospital* - Policy pays initial deductible and co-insurance. After 150 days, pays 90% of expense up to 365 days<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day. After 100th day, nothing | *Medical* - After first $200, out-of-pocket, of Medicare-approved charges, policy pays 20% Medicare approved charges |
| United American Ins. Co.<br>P.O. Box 810<br>Dallas TX 75221<br>Form MVXC (48) | $671 for everyone | Health questions asked | 60 days | 60% | *Hospital* - Policy pays deductible and co-insurance to 100th day. After 150 days pays 90% up to 365 days<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day | *Medical* - After you pay $75 deductible, policy pays 20% of Medicare-approved charges |
| United American Insurance Company<br>P. O. Box 810<br>Dallas TX 75221<br>Form No. MAXC + (48) | $803 for everyone | Health questions asked | 60 days | 60% | *Hospital* - Policy pays full deductible and co-insurance<br>*Skilled Nursing Facility*<br>Co-insurance to the 100th day. Pays $50 a day for 265 days | *Medical* - After $75 deductible, 50% of covered expense not paid by Medicare. Covered expense is up to 140% of Medicare-approved charge. After $200 of benefits paid in calendar year, all additional covered expense not covered by Medicare is paid<br>*Other Benefits* - In-hospital private nursing care. Premium refund for accidental death |



250

| | 1986 Annual Premium (submit to change) | Eligibility Standards* | Waiting Period** for Pre-existing Conditions | 1st Year Commission to Agent | Brief Description of Benefits*** | |
|---|---|---|---|---|---|---|
| MEDICARE REPLACEMENT**** | | | | | Medicare Part A | Medicare Part B |
| Family Health Plan Cooperative<br>12500 W. Bluemound Road<br>Elm Grove WI 53122-0925<br>Form No. M-10-85-A | $275.88 for everyone | None | None | None | *Hospital* - In addition to regular Medicare benefits, policy pays full deductible and co-insurance. After 100 days, pays 100%<br>*Skilled Nursing Facility*<br>Co-insurance to 100th day. After 100th day, 100% of charges | *Medical* - In addition to regular Medicare, policy pays 100% of medical expenses approved by Family Health Plan physician<br>*Other Benefits* - Vision and dental benefits available at additional cost |
| Available in Milwaukee, Ozaukee, Racine, Walworth, Washington and Waukesha Counties only | | | | | | |

* Whenever an application includes health questions, the company may use this information to refuse to issue a policy, to limit or exclude the coverage for a specific named condition for six months or void the policy because of misinformation on the application.

** Pre-existing condition waiting periods may be applied only to conditions for which you were treated in the 6 months before you applied for the policy and which have not been disclosed on the application or excluded by specific description.

*** This is a brief description of benefits. Check the Outline of Coverage and the policy itself for details. YOUR MEDICARE HANDBOOK, available from your Social Security office, explains Medicare benefits. Skilled Nursing Facility benefits are provided only if stay is covered by Medicare.

**** A Medicare Replacement policy is a policy offered by a health maintenance organization which has entered into a direct risk contract with the federal government to provide Medicare benefits to enrollees. In Wisconsin these policies are required to offer additional benefits. Full benefits generally are paid only if services are received from participating providers in the geographical area served by the plan.

Medicare Part A covers hospitalization, including room and board, nursing charges and miscellaneous charges. Medicare pays first 60 days in full after $492. From the 61st through 150th day, costs are shared. After 150th day, Medicare pays nothing. Medicare also covers some posthospital stays in a Skilled Nursing Facility. If the stay is covered, Medicare pays for the first 20 days. From the 21st through 100th day, costs are shared. After 100th day, Medicare pays nothing.

Medicare Part B covers many medical costs. After $75 annual deductible, Medicare pays 80% of Medicare-approved charges for covered expenses. Most companies pay Part B benefits based on Medicare's approved charges. Some companies make their own determinations of usual and customary charges. Medicare-approved charges and usual and customary charges as determined by the company are often less than you are actually charged by a doctor or other health professional.

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MEDICARE SUPPLEMENT EXPERIENCE
(POLICIES MARKETED IN 1983)

MEDICARE SUPPLEMENT 2

| Name of Company | Policy Form # | No. in Force (12/31/83) | No. Issued 1983 | No. excluded or rejected | Earned premium 1983 | Incurred Claims 1983 | Loss Ratio 1983 |
|---|---|---|---|---|---|---|---|
| Aid Assoc. for Luth. | 4717WI[1] | 1,018 | 389 | 20 ex. 95 rej. | $ 418,551 | $ 137,737 | 32.9% |
| Benefit Trust Life Co. | #MSW-182 | 615 | 620 | 0 | $ 147,199 | $ 45,553 | 31.0% |
| Blue Cross & Blue Shield United of Wisconsin | HX-1425 | 6,746 | 4,800 | 0 | $1,871,941 | $ 1,194,473 | 63.8% |
| Central States | #286 WISC | 851 | 947 | | $ 131,664 | $ 19,638 | 15.0% |
| Continent. Cas | #67720 | 3,853 | 2,318 | 0 | $1,658,513 | $ 1,304,855 | 78.7% |
| Federal Home Life Ins. Co. | #4500<br>#4535(S) | 2,110<br>136 | 1,958<br>136 | N/A | $ 958,031<br>$ 12,272 | $ 518,371<br>$ 3,948 | 54.1%<br>32.2% |
| Nat. States | SMW-2 | 40 | 43 | 41 | $ 23,121 | $ 0 | -- |
| Physicians Mut. Ins. Co. | 7192K and 182 | 12,095 | 6,434 | 65 | $4,325,377 | $ 2,891,628 | 67% |
| Rural Sec. Life | #HP-191 | 2,546 | 248 | 220 rej. | $1,113,288 | $ 890,501 | 80% |
| Time Insurance Company | #682 | 277 | 0 | 0 | $ 94,811 | $ 20,425 | 21% |
| WPS | #13789-B51 | 4,533 | 3,662 | 946 | $ 932,051 | $ 652,660 | 70% |
| Total | | 34,684 | 21,555 | 1,387 | $11,686,849 | $ 7,679,789 | Ave. 49.54% |

1. Also includes #4732 and #4732 2-81.
N/A = Not Available

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Prepared by: Mary Grossman
06/28/84

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MEDICARE SUPPLEMENT EXPERIENCE
(POLICIES MARKETED IN 1983)

MEDICARE SUPPLEMENT 3

| Name of Company | Policy Form # | No. in Force (12/31/83) | No. Issued 1983 | No. excluded or rejected | Earned premium 1983 | Incurred Claims 1983 | Loss Ratio 1983 |
|---|---|---|---|---|---|---|---|
| Am. Rep. | A-2400 WI | 190 | 65 | 13 | $ 72,722 | $ 40,572 | 56% |
| Bankers Life | GWI519 | 4 | 4 | N/A | N/A | N/A | N/A |
| Bankers Life & Casualty | 75D(1982) | 2,551 | 1,926 | 0 | $ 1,323,464 | $ 840,276 | 63.5% |
| Bankers Life & Casualty | #75R | 434 | 485 | 1 | $ 20,864 | $ 8,342 | 40.0% |
| Benefit Trust Life Co. | MSP-182WI | 211 | 213 | 0 | $ 36,727 | $ 10,961 | 30.0% |
| Globe Life & Accident | #MCP-2-MWI | 101 | 101 | 0 | $ 34,297 | $ 29,906 | 87.0% |
| Guarantee Trust Life | #80335 | 1,679 | N/A | 0 | $ 241,479 | $ 41,760 | 17.3% |
| Lutheran Brotherhood | H1-MS-1W1 | 137 | 151 | 0 | $ 19,378 | $ 7,668 | 39.6% |
| Medico Life | #ML408 | 35 | 37 | 1 | $ 1,038 | $ 160 | 15% |
| Medico Life | #ML384Y | 67 | 71 | 2 | $ 20,312 | $ 7,549 | 37% |
| MidAmerica Mutual Life | U-1085.3[2] | 292 | 94 | 30 | $ 114,281 | $ 41,275 | 36.2% |
| Mutual of Omaha | M-37 Series | 1,381 | 1,265 | 0 | $ 387,525 | $ 156,246 | 40.32% |
| Mutual of Omaha | M39-Series | 3,948 | 3,749 | 0 | $ 1,025,408 | $ 551,284 | 53.76% |
| Mut.Protective | #MP408 | 381 | 442 | 4 | $ 19,955 | $ 6,826 | 34% |
| Mut.Protective | #MP384Y | 238 | 287 | 4 | $ 109,845 | $ 34,700 | 31% |
| Nat. States | SMM-3 | 1,623 | 1,588 | 1,032 | $ 797,026 | $ 84,894 | 10.7% |
| Nat. Travelers Life | #6160 WI | 13 | 14 | 1 | $ 3,081 | 0 | 0 |
| New York Life Ins. Co. | #8145-8 | 7 | 7 | 0 | $ 3,219 | $ 1,608 | 50% |
| Total | | 13,332 | 10,570 | 1,078 | $ 4,230,631 | $1,864,027 | Avg. 40.0% |
| TOTAL ALL POLICIES | | 48,016 | 32,125 | 2,474 | $15,917,480 | $3,728,054 | Avg. 44% |

2. Includes all Medicare Supplement policies.
N/A = Not Available
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Prepared by: Mary Grossman
06/28/84



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1983 MEDICARE SUPPLEMENT EXPERIENCE*
ALL MEDICARE SUPPLEMENT POLICIES IN FORCE DECEMBER 31, 1983

| Name of Company | Total in Force 12/31/83 | 1983 Earned Premium | 1983 Incurred Claims | 1983 Loss Ratio |
|---|---|---|---|---|
| Aid Assn. Lutherans | 1,018 | $ 418,551 | $ 137,737 | 32.9% |
| American Republic | 190 | 76,186 | 42,246 | 55.0 |
| Bankers Life | 4,487 | - | - | - |
| Bankers Life & Cas. | 11,967 | 8,077,554 | 4,553,803 | 56.4 |
| Benefit Trust Life | 833 | 183,926 | 56,514 | 30.73 |
| Blue Cross & Blue Shield | 105,315 | 32,328,148 | 27,171,388 | 84.0 |
| Cent. Sts. Health & Life | 890 | 150,179 | 27,277 | 18.0 |
| Continental Casualty | 4,242 | 1,724,562 | 1,365,826 | 79.0 |
| Federal Home Life | 2,558 | 1,181,181 | 660,350 | 55.9 |
| Globe Life | 225 | 75,589 | 56,719 | 75.0 |
| Interstate Assur. | 36 | 10,173 | 6,618 | 65.0 |
| Lumbermens Mutual | 60 | 113,255 | 104,478 | 92.0 |
| Lutheran Brotherhood | 233 | 24,270 | 10,380 | 43.0 |
| Mass. Indemnity Life | 29 | 5,126 | 1,025 | 20.0 |
| Medico Life | 206 | 46,564 | 35,062 | 75.0 |
| MidAmerica Mut. Life | 292 | 114,281 | 41,275 | 36.2 |
| Mutual of Omaha | 11,185 | 4,986,262 | 2,883,698 | 57.83 |
| Mutual Protective | 671 | 140,990 | 46,680 | 33.0 |
| National Home Life | 90 | 40,401 | 29,897 | 74.0 |
| National States | 3,043 | 1,248,539 | 442,292 | 35.4 |
| National Travelers | 13 | 3,081 | - | - |
| New York Life | 14 | 7,049 | 2,522 | 35.8 |
| Pennsylvania | 79 | 20,024 | 4,168 | 24.73 |
| Physicians Mutual | 12,095 | 4,325,377 | 2,891,628 | 67.0 |
| Rural Security | 2,546 | 1,113,288 | 890,501 | 80.0 |
| Time | 822 | 365,804 | 146,992 | 40.0 |
| Union Labor | 38 | 3,230 | 5,703 | 177.0 |
| WPS | 34,664 | 23,957,065 | 16,991,912 | 70.9 |
| Total | 197,841 | $80,740,655 | $58,606,691 | 58.2% |

* Includes all companies reporting Medicare Supplement business in 1983.

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6/27/84

Prepared by:
Mary Grossman



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| Name of Company | Policy Form Number | Number in Force 12/31/84 | Number Issued 1984 | Number Excluded or Rejected | Earned Premium 1984 | Incurred Claims 1984 | Loss Ratio 1984 |
|---|---|---|---|---|---|---|---|
| Mutual Protective Ins Co | Individual | | | | | | |
| | 385 | 37 | 0 | 0 | 7,849 | 5,083 | 64.76 |
| | 384Y | 255 | 177 | 4 | 183,996 | 66,099 | 35.92 |
| | 408 | 608 | 519 | 1 | 109,021 | 29,608 | 27.16 |
| National Home Life Assurance Co | Individual | | | | | | |
| | 4200 WI | 74 | 0 | 0 | 37,165** | 25,857** | 70.0** |
| | ** Estimated | | | | | | |
| National States Ins Co | SMW | 946 | 0 | 0 | 333,149 | 163,545 | 49.1 |
| | SMW-3 | 1,429 | 619 | 588 | 743,179 | 412,296 | 55.5 |
| | SMW-2 | 437 | 483 | 459 | 281,895 | 13,873 | 4.9 |
| National Travelers Life Co | Other | | | | | | |
| | HP6160 WI | 28 | 18 | 0 | 10,667 | 7,196 | 67.46 |
| New York Life Ins Co | 8145-8 | 237 | 230 | 0 | 84,869 | 66,676 | 78.6 |
| | 7745 | 7 | 0 | 0 | 3,073 | 3,284 | 106.9 |
| Pekin Life Ins Co | H10 | 5 | 5 | 0 | 2,060 | 797 | 38.22 |
| | H15 | 13 | 13 | 0 | 5,556 | 3,164 | 56.95 |
| Physicians Mutual Ins Co | 192K | 4,262 | 3,461 | 36 | 1,556,853 | 899,861 | 57.8 |
| | 182 | 8,764 | 0 | 0 | 5,344,613 | 3,302,971 | 61.8 |
| Rural Security Life Ins Co | HP-191 | 2,605 | 198 | 100 | 1,275,000 | 891,500 | 69.9 |
| Time Ins Co | 603 | 452 | 0 | 0 | 206,981 | 108,406 | 41.5 |
| | 682 | 374 | 200 | 14 | 232,280 | 109,383 | 47.1 |
| Union Labor Life Ins Co | Individual | | | | | | |
| | Ind. A.H. 5065 | 6 | 3 | 0 | 510 | 798 | 156.0 |
| | Ind. A.H. 5090-83 | 318 | 318 | | 95,231 | 75,226 | 79.00 |







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| Name of Company | Policy Form Number | Number in Force 12/31/84 | Number Issued 1984 | Number Excluded or Rejected | Earned Premium 1984 | Incurred Claims 1984 | Loss Ratio 1984 |
|---|---|---|---|---|---|---|---|
| | Other | | | | | | |
| | 78322-5 | 5 | 0 | 0 | 1,984 | 355 | 17.8 |
| | 80335 | 2,831 | 0 | 0 | 707,384 | 160,168 | 22.6 |
| | 80369R-1 | 2,583 | 0 | 0 | 357,824 | 234,545 | 65.5 |
| | 81337R-7 | 801 | 0 | 0 | 214,079 | 210,967 | 98.5 |
| | 81337R-8 | 1,922 | 0 | 0 | 255,905 | 284,762 | 111.2 |
| | Z3916 | 82 | 0 | 0 | 42,795 | 16,315 | 38.1 |
| Lutheran Brotherhood | Individual | | | | | | |
| | HI-MS-I | 210 | 198 | 0 | 80,885 | 25,223 | 31.2 |
| | HRI-MDC | 159 | 78 | 0 | 22,137 | 12,248 | 55.3 |
| Medico Life Ins Co | Other | | | | | | |
| | 384Y | 228 | 243 | 6 | 90,259 | 23,677 | 26.23 |
| | 408 | 112 | 120 | 1 | 15,073 | 4,170 | 27.66 |
| MidAmerica Mutual | U-1085 | 420 | 162 | 15 | 166,409 | 59,935 | 36.0 |
| Mutual of Omaha Ins Co | Other | | | | | | |
| | 50VB | 1,732 | 0 | 0 | 856,462 | 410,526 | 47.93 |
| | 51VB | 888 | 0 | 0 | 422,140 | 241,999 | 57.33 |
| | 20AGHO | 42 | 0 | 0 | 23,610 | 8,652 | 36.65 |
| | 2CMO | 221 | 0 | 0 | 119,592 | 52,281 | 43.72 |
| | 3CMO | 88 | 0 | 0 | 50,071 | 26,103 | 52.13 |
| | 15CMO | 243 | 0 | 0 | 246,094 | 102,931 | 41.83 |
| | 16CMO | 506 | 0 | 0 | 500,596 | 182,331 | 36.42 |
| | 44CMO | 186 | 0 | 0 | 125,780 | 55,907 | 44.45 |
| | 48CMO | 3 | 0 | 0 | 1,917 | 0 | 0 |
| | 50CMO | 303 | 0 | 0 | 293,720 | 142,843 | 48.63 |
| | 51CMO | 14 | 0 | 0 | 13,089 | 5,872 | 44.86 |
| | M37 | 1,783 | 922 | 0 | 915,375 | 352,285 | 38.49 |
| | M39 | 5,071 | 2,326 | 0 | 3,555,401 | 1,649,964 | 46.41 |





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| Name of Company | Policy Form Number | Number in Force 12/31/84 | Number Issued 1984 | Number Excluded or Rejected | Earned Premium 1984 | Incurred Claims 1984 | Loss Ratio 1984 |
|---|---|---|---|---|---|---|---|
| Central States Health & Life Co of Omaha | Individual | | | | | | |
| | 219 | 14 | 0 | 0 | 6,986 | 3,211 | 46.0 |
| | 279 | 8 | 0 | 0 | 6,356 | 622 | 10.4 |
| | 282 | 2 | 0 | 0 | 972 | 411 | 42.3 |
| | Other | | | | | | |
| | 286 | 1,656 | 1,581 | 0 | 788,131 | 333,633 | 42.3 |
| | 288 | 5 | 6 | 0 | 2,922 | 4,624 | 158.2 |
| | 289 | 8 | 4 | 0 | 1,175 | (11,530) | 0.0 |
| Continental Casualty Co | Other | | | | | | |
| | 65000 | 36 | | | 2,333 | 5,306 | 227.4 |
| | 65003 | 278 | | | 49,982 | (17,978) | 0 |
| | 66353 | 4 | | | 1,858 | 2,309 | 124.3 |
| | 67720 | 4,242 | 1,573 | | 2,328,048 | 335,530 | 14.4 |
| DeanCare | Other | | | | | | |
| | 1059-0484 | 1,007 | 1,007 | 0 | 150,051 | 149,588 | 99.0 |
| Globe Life & Accident Co | Individual | | | | | | |
| | OA640 | 84 | 0 | 0 | 31,647 | 14,641 | 46.0 |
| | Medsup-2 | 7 | 0 | 0 | 4,000 | 7,538 | 188.0 |
| | MCP-2 | 60 | 0 | 0 | 54,841 | 33,989 | 62.0 |
| | MCP-3 | 12 | 12 | 0 | 2,641 | 409 | 15.0 |
| | Great Commonwealth | 3 | 0 | 0 | 599 | 528 | 88.0 |
| Greater Marshfield Community Health Plan | Individual | | | | | | |
| | FGP-631 | 9,829 | N/A | 0 | 5,952,023 | 4,954,173 | 83.2 |
| Federal Home Life Ins Co | Other | | | | | | |
| | 4492 | 272 | 0 | 0 | 192,716 | 96,566 | 50.1 |
| | 4500 | 1,276 | 0 | 0 | 992,655 | 443,187 | 44.6 |
| | 4535 | 617 | 475 | 0 | 332,337 | 144,698 | 43.5 |
| Guarantee Trust Life Ins Co | Individual | | | | | | |
| | 71306-R | 31 | 0 | 0 | 571 | 19 | 3.3 |
| | 80331 | 59 | 0 | 0 | 32,190 | 12,772 | 39.6 |
| | 71306 | 451 | 0 | 0 | 181,815 | 139,167 | 76.5 |



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## MEDICARE SUPPLEMENT BUSINESS - 1984

| Name of Company | Policy Form Number | Number in Force 12/31/84 | Number Issued 1984 | Number Excluded or Rejected | Earned Premium 1984 | Incurred Claims 1984 | Loss Ratio 1984 |
|---|---|---|---|---|---|---|---|
| Aid Assoc for Lutherans | Individual | | | | | | |
| | 47322-81 | 1,454 | 523 | 24 excluded 175 rejected | $ 697,991 | $ 254,952 | 36.5% |
| Am. Motorists Ins Co | Other | | | | | | |
| | IM 5847 | 0 | 0 | 0 | 450 | (316) | (70.2) |
| Am. Republic Ins Co | Individual | | | | | | |
| | A-2400 | 211 | 59 | 12 | 95,866 | 44,850 | 47.0 |
| | A-2535 (Rider) | 78 | 40 | 9 | 8,221 | 7,044 | 86.0 |
| Bankers Life & Casualty | Individual | | | | | | |
| | 75D | 4,274 | 0 | 0 | 4,424,535 | 1,689,537 | 38.2 |
| | 75D (1982) | 1,346 | 107 | 0 | 1,159,154 | 514,564 | 44.4 |
| | 75R | 4,529 | 4,870 | 0 | 4,039,329 | 2,127,617 | 52.7 |
| | 97F | 1,226 | 1,251 | 0 | 387,750 | 67,167 | 17.3 |
| Benefit Trust Life Ins Co | Individual | | | | | | |
| | MSP-182WI | 287 | 129 | 0 | 162,159 | 61,475 | 37.91 |
| | MSW-182 | 908 | 499 | 0 | 511,926 | 258,182 | 50.43 |
| Blue Cross & Blue Shield United of Wisconsin | Group | | | | | | |
| | Medicare Extended | 6,688 | 488* | 0 | 1,960,150 | 1,743,603 | 89.0 |
| | Medex Preferred | 695 | 131* | 0 | 255,872 | 228,200 | 89.2 |
| | Medex - Plus | 819 | 572* | 0 | 267,417 | 174,425 | 65.2 |
| | Individual | | | | | | |
| | Medex - Preferred | 33,667 | 0 | 0 | 15,464,031 | 11,889,343 | 76.9 |
| | Other Individual | | | | | | |
| | Medex - Plus | 19,572 | 13,974* | 56 rejected | 4,871,399 | 3,011,937 | 61.8 |
| | Medicare Extended | 41,901 | 0 | 0 | 13,371,826 | 12,667,739 | 94.7 |

* These figures represent new sales and/or transfers from non-Medicare contracts.

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| Name of Company | Policy Form Number | Number in Force 12/31/84 | Number Issued 1984 | Number Excluded or Rejected | Earned Premium 1984 | Incurred Claims 1984 | Loss Ratio 1984 |
|---|---|---|---|---|---|---|---|
| United American Ins Co | MCXC | 1,082 | 0 | 0 | 538,623 | 366,783 | 68.1 |
| | MAXC | 4,146 | 4,963 | 0 | 1,375,010 | 246,063 | 17.9 |
| | DMXC | 863 | 921 | 0 | 272,839 | 29,961 | 11.0 |
| Wisconsin Physicians Service Ins Co | Individual | | | | | | |
| | WPS MedPlus #22500-725 | 17,809 | 0 | 0 | 20,254,201 | 15,370,612 | 75.9 |
| | Med. PlusConv 10524-051-8107 | 470 | 200 | 0 | 0 | 0 | 0.0 |
| | Med. Comp. 1193-051-8106 | 8,710 | 0 | 0 | 3,288,949 | 1,925,581 | 58.5 |
| | Other | | | | | | |
| | Med. Comp. II-13789-851-8207 | 6,553 | 2,342 | 576 | 2,128,002 | 1,069,567 | 50.3 |
| TOTAL | | 218,639 | 46,020 | 2,076 | 106,245,078 | 70,851,981 | 66.6 |

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Prepared by: Carol Waugh
Mary Grosemen
Office of the Commissioner of Insurance
123 West Washington Avenue
Madison WI 53702





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APPENDIX H



VOLUNTARY CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES

SEC. 507. (a) Title XVIII of the Social Security Act is amended by adding at the end thereof the following new section:

"VOLUNTARY CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES

42 USC 1395ss.

"SEC. 1882. (a) The Secretary shall establish a procedure whereby medicare supplemental policies (as defined in subsection (g)(1)) may be certified by the Secretary as meeting minimum standards and requirements set forth in subsection (c). Such procedure shall provide an opportunity for any insurer to submit any such policy, and such additional data as the Secretary finds necessary, to the Secretary for his examination and for his certification thereof as meeting the standards and requirements set forth in subsection (c). Such certification shall remain in effect if the insurer files a notarized statement with the Secretary no later than June 30 of each year stating that the policy continues to meet such standards and requirements and if the insurer submits such additional data as the Secretary finds necessary to independently verify the accuracy of such notarized statement.

Emblem.

Where the Secretary determines such a policy meets (or continues to meet) such standards and requirements, he shall authorize the insurer to have printed on such policy (but only in accordance with such requirements and conditions as the Secretary may prescribe) an emblem which the Secretary shall cause to be designed for use as an indication that a policy has received the Secretary's certification. The Secretary shall provide each State commissioner or superintendent of insurance with a list of all the policies which have received his certification.

List of certified policies.

State regulatory program, standards and requirements.

"(b)(1) Any medicare supplemental policy issued in any State which the Supplemental Health Insurance Panel (established under paragraph (2)) determines has established under State law a regulatory program that—

"(A) provides for the application of standards with respect to such policies equal to or more stringent than the NAIC Model Standards (as defined in subsection (g)(2)(A));

"(B) includes a requirement equal to or more stringent than the requirement described in subsection (c)(2); and

"(C) provides for application of the standards and requirements described in subparagraphs (A) and (B) to all medicare supplemental policies (as defined in subsection (g)(1)) issued in such State,

shall be deemed (for so long as the Panel finds that such State regulatory program continues to meet the standards and requirements of this paragraph) to meet the standards and requirements set forth in subsection (c).

Supplemental Health Insurance Panel, establishment.

"(2)(A) There is hereby established a panel (hereinafter in this section referred to as the 'Panel') to be known as the Supplemental Health Insurance Panel. The Panel shall consist of the Secretary, who shall serve as the Chairman, and four State commissioners or superintendents of insurance, who shall be appointed by the President and serve at his pleasure. Such members shall first be appointed not later than December 31, 1980.

Quorum.

"(B) A majority of the members of the Panel shall constitute a quorum, but a lesser number may conduct hearings.



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"(C) The Secretary shall provide such technical, secretarial, clerical, and other assistance as the Panel may require.

"(D) There are authorized to be appropriated such sums as may be necessary to carry out this paragraph. Appropriation authorization.

"(E) Members of the Panel shall be allowed, while away from their homes or regular places of business in the performance of services for the Panel, travel expenses (including per diem in lieu of subsistence) in the same manner as persons employed intermittently in the Government service are allowed expenses under section 5703 of title 5, United States Code. Travel expenses.

"(c) The Secretary shall certify under this section any medicare supplemental policy, or continue certification of such a policy, only if he finds that such policy— Medicare supplemental policy, certification criteria.

"(1) meets or exceeds (either in a single policy or, in the case of nonprofit hospital and medical service associations, in one or more policies issued in conjunction with one another) the NAIC Model Standards; and

"(2) can be expected (as estimated for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience and earned premiums for such period and in accordance with accepted actuarial principles and practices) to return to policyholders in the form of aggregate benefits provided under the policy, at least 75 percent of the aggregate amount of premiums collected in the case of group policies and at least 60 percent of the aggregate amount of premiums collected in the case of individual policies.

For purposes of paragraph (2), policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies. Individual policies.

"(dX1) Whoever knowingly or willfully makes or causes to be made or induces or seeks to induce the making of any false statement or representation of a material fact with respect to the compliance of any policy with the standards and requirements set forth in subsection (c) or in regulations promulgated pursuant to such subsection, or with respect to the use of the emblem designed by the Secretary under subsection (a), shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than 5 years, or both. False statement or representation, penalties and fines.

"(2) Whoever falsely assumes or pretends to be acting, or misrepresents in any way that he is acting, under the authority of or in association with, the program of health insurance established by this title, or any Federal agency, for the purpose of selling or attempting to sell insurance, or in such pretended character demands, or obtains money, paper, documents, or anything of value, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than 5 years, or both.

"(3XA) Whoever knowingly sells a health insurance policy to an individual entitled to benefits under part A or enrolled under part B of this title, with knowledge that such policy substantially duplicates health benefits to which such individual is otherwise entitled, other than benefits to which he is entitled under a requirement of State or Federal law (other than this title), shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than 5 years, or both. 42 USC 1395c, 1395j



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consumers and the aged, conduct a comprehensive study and evaluation of the comparative effectiveness of various State approaches to the regulation of medicare supplemental policies in (i) limiting marketing and agent abuse, (ii) assuring the dissemination of such information to individuals entitled to benefits under this title (and to other consumers) as is necessary to permit informed choice, (iii) promoting policies which provide reasonable economic benefits for such individuals, (iv) reducing the purchase of unnecessary duplicative coverage, (v) improving price competition, and (vi) establishing effective approved State regulatory programs described in subsection (b).

"(B) Such study shall also address the need for standards or certification of health insurance policies, other than medicare supplemental policies, sold to individuals eligible for benefits under this title.

Report to Congress.

"(C) The Secretary shall, no later than January 1, 1982, submit a report to the Congress on the results of such study and evaluation, accompanied by such recommendations as the Secretary finds warranted by such results with respect to the need for legislative or administrative changes to accomplish the objectives set forth in subparagraphs (A) and (B), including the need for a mandatory Federal regulatory program to assure the marketing of appropriate types of medicare supplemental policies, and such other means as he finds may be appropriate to enhance effective State regulation of such policies.

Report to Congress.

"(2) The Secretary shall submit to the Congress no later than July 1, 1982, and periodically as may be appropriate thereafter (but not less often than once every 2 years), a report evaluating the effectiveness of the certification procedure and the criminal penalties established under this section, and shall include in such reports an analysis of—

"(A) the impact of such procedure and penalties on the types, market ...are, value, and cost to individuals entitled to benefits under this title of medicare supplemental policies which have been certified by the Secretary;

"(B) the need for any change in the certification procedure to improve its administration or effectiveness; and

"(C) whether the certification program and criminal penalties should be continued.

Medicare supplemental policy, definition

"(g)(1) For purposes of this section, a medicare supplemental policy is a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under this title, which provides reimbursement for expenses incurred for services and items for which payment may be made under this title but which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed pursuant to this title; but does not include any such policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or for members or former members (or combination thereof) of the labor organizations. For purposes of this section, the term 'policy' includes a certificate issued under such policy.

"Policy."

"NAIC Model Standards."

"(2) For purposes of this section:

"(A) The term 'NAIC Model Standards' means the 'NAIC Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act', adopted by the



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National Association of Insurance Commissioners on June 6, 1979, as it applies to medicare supplement policies.

Definition

"(B) The term 'State with an approved regulatory program' means a State for which the Panel has made a determination under subsection (b)(1).

"(C) The State in which a policy is issued means—

"(i) in the case of an individual policy, the State in which the policyholder resides; and

"(ii) in the case of a group policy, the State in which the holder of the master policy resides.

Regulations

"(h) The Secretary shall prescribe such regulations as may be necessary for the effective, efficient, and equitable administration of the certification procedure established under this section. The Secretary shall first issue final regulations to implement the certification procedure established under subsection (a) not later than March 1, 1981.

Emblem usage, effective date.

"(i)(1) No medicare supplemental policy shall be certified and no such policy may be issued bearing the emblem authorized by the Secretary under subsection (a) until July 1, 1982. On and after such date policies certified by the Secretary may bear such emblem, including policies which were issued prior to such date and were subsequently certified, and insurers may notify holders of such certified policies issued prior to such date using such emblem in the notification.

"(2)(A) The Secretary shall not implement the certification program established under subsection (a) with respect to policies issued in a State unless the Panel makes a finding that such State cannot be expected to have established, by July 1, 1982, an approved State regulatory program meeting the standards and requirements of subsection (b)(1). If the Panel makes such a finding, the Secretary shall implement such program under subsection (a) with respect to medicare supplemental policies issued in such State, until such time as the Panel determines that such State has a program that meets the standards and requirements of subsection (b)(1).

Panel findings, transmittal to congressional committees, effective date.

"(B) Any finding by the Panel under subparagraph (A) shall be transmitted in writing, not later than January 1, 1982, to the Committee on Finance of the Senate and to the Committee on Interstate and Foreign Commerce and the Committee on Ways and Means of the House of Representatives and shall not become effective until 60 days after the date of its transmittal to the Committees of the Congress under this subparagraph. In counting such days, days on which either House is not in session because of an adjournment sine die or an adjournment of more than three days to a day certain are excluded in the computation.

"(j) Nothing in this section shall be construed so as to affect the right of any State to regulate medicare supplemental policies which, under the provisions of this section, are considered to be issued in another State.".

(b) The amendment made by this section shall become effective on the date of the enactment of this Act, except that the provisions of paragraph (4) of section 1882(d) of the Social Security Act (as added by this section) shall become effective on July 1, 1982.

Effective date. 42 USC 1395ss note.

Ante, p. 476.

Approved June 9, 1980.

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LEGISLATIVE HISTORY:

HOUSE REPORTS: No. 96-100 (Comm. on Ways and Means) and No. 96-944 (Comm. of Conference).

SENATE REPORT No. 96-408 (Comm. on Finance).

CONGRESSIONAL RECORD:

Vol. 125 (1979): Sept. 6, considered and passed House.
Dec. 5, considered in Senate.

Vol. 126 (1980): Jan. 30, 31, considered and passed Senate, amended.
May 22, House agreed to conference report.
May 29, Senate agreed to conference report.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS:

Vol. 16, No. 24 (1980): June 9, Presidential statement.



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APPENDIX I

SUPREME COURT : NEW YORK COUNTY VZ 9

SPECIAL TERM : PART I

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AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS,

Plaintiff, INDEX NO.

- against - 20674/79

AMERICAN BROADCASTING COMPANIES, INC., et al.,

Defendants.

----------X

ALFRED M. ASCIONE, J.:

In this libel action, seeking damages of $175 million, brought by plaintiff American Family Life Assurance Company of Columbus [Georgia] ("AFLAC") against the defendants American Broadcasting Companies, Inc. ("ABC"), Roone Arledge, Av Westin, Margaret Osmer, Karen Burns, et al., in connection with a three-part series entitled "Insurance Fraud" and broadcast by ABC on its television network as part of the regularly scheduled evening news program, "World News Tonight", on November 27, 28 and 29, 1978, defendants' motion for summary judgment dismissing the complaint is granted.

First, some background. AFLAC is a wholly-owned subsidiary of the American Family Corporation of Columbus, Georgia, a public company listed on the New York Stock Exchange, and was incorporated in 1955 by its founder and chairman, John B. Amos, an attorney. By the time of the broadcasts in question, in



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1978, AFLAC was the number-one seller of cancer insurance in the United States (see Exhibit h to the moving papers, Consumer Reports, June 1978, p. 336, "Cashing In On Fear: The Selling of Cancer Insurance"). Indeed, cancer insurance had become such a hot item that plaintiff was selling 3,000 policies a day and had a total of over 4.7 million cancer policies in force worldwide covering 12 million people.

By its own account, AFLAC now sells the major share of cancer (sometimes called "dread disease") insurance sold in the world. Mr. Amos, in AFLAC advertisements published nationally during 1977, said: "Our company issues and has in force more insurance policies limited to loss from cancer than all other insurance companies in the world combined." (See advertisement with headline "Twenty Years of Stewardship -- Cancer Insurance Comes of Age," Exhibit H to moving affidavit).

However, three states, New York, New Jersey and Connecticut, have adopted strict restrictions on or banned the sale of cancer insurance and plaintiff does not sell such insurance in those states.

According to plaintiff, its cancer insurance, though supplemental in nature, is not designed to meet the so-called "Medigap", which is the ever-widening gap between what Medicare pays and the actual medical costs of our elderly. By far, the majority of AFLAC's policyholders are not the elderly. It does



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appear, however, that 11.1% or some 462,000 of plaintiff's policyholders were over the age of sixty-five in 1978, a significant number.

Blue Cross/Blue Shield and a number of major insurance companies do offer comprehensive health insurance intended to narrow the medigap and to provide supplemental protection to the elderly against cancer or any other medical condition beyond what Medicare pays (Medicare paid 38% in 1978), though no insurance completely fills the gap.

Then, we find AFLAC and the other insurers who have been very successful selling cancer insurance in response to the widespread fear of this dread disease and the substantial medical costs involved. Whether or not such insurance is intended to recover medical costs not reimbursed by Medicare, the elderly are particularly vulnerable to the lure of insurance protection against cancer because Medicare will pay only 38% of their medical costs, which they know will be substantial and may drain their remaining resources. For example, AFLAC in its 1977 advertisement "Cancer Insurance Comes of Age" stated:

> "We feel, however, that above all else our cancer policy provides to the insured Peace of Mind. Peace of mind that enough money will be available to fill the gaps --- to insure that he will never be a burden upon loved ones -- that life savings or plans for college educations and a fair start in life for the coming generation -- will not be destroyed by a long and expensive battle with cancer ..."



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The record in this case shows that, in 1978, two/thirds of the American elderly, or 15 million people, had at least one medi-gap policy; many had two or more and some as many as thirty policies. It is estimated that almost $4 billion was spent by the elderly in 1978 on such policies. Of that amount, Blue Cross accounted for $2 billion and group insurers about $500 million. Some $1.5 billion was spent on policies sold to individuals by companies such as AFLAC. The ABC series was concerned with the latter group of insurers.

Serious questions had been raised about the marketing, sales and claims practices of some of the insurers and agents selling cancer insurance. Although these companies did not create the climate of fear which exists about cancer, little reluctance was shown in making the most of it in their marketing or sales pitch to the elderly, who, as noted, are especially susceptible to sales techniques which prey on such fear and the inadequacy of Medicare benefits should they fall victim to cancer.

Such fear has led to abuses by some unscrupulous insurers and their agents who "overload" senior citizens with a number of policies which are duplicative and may cancel each other out due to coordination of benefits clauses. Also, a number of companies have very low loss/benefit ratios, that is, the amount paid on claims in proportion to the premiums received. Insurance experts tell us that the higher the loss/benefit ratio the better it is for the policyholders. Blue Cross, for example, pays 80 cents or more for each dollar of premium. Some companies have



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loss/benefit ratios of under 50 cents (in this case, it is asserted that plaintiff's loss/benefit ratio for 1977 was about 42 cents). Such low ratios are an indication that most of the premium dollar goes to pay agents' commissions, high overhead and administrative costs, and profits, rather than claims.

Thus, it is clear that there was and is a public controversy concerning the efficacy or economic value of dread disease or single-purpose supplemental health insurance for the elderly, when compared to supplemental comprehensive health insurance such as that offered by Blue Cross/Blue Shield or the other major commercial insurance companies. Obviously, should a policyholder suffer from a disease or medical condition other than the specific ailment insured, no coverage is afforded. Such policies commonly contain exclusions or waiting periods for pre-existing conditions, and a level of benefits for hospitalization, physicians' fees and other medical expenses, when there is coverage, that often fails to meet the real need of the elderly for genuine supplementary or medigap protection, and which the elderly are falsely led to believe such insurance afforded.

Due to a significant number of complaints concerning such abuses to the Select Committee on Aging of the U.S. House of Representatives in the 95th Congress, Second Session, the Committee Staff was directed to conduct an investigation on the subject, "Abuses in the Sale of Health Insurance to the Elderly in Supplementation of Medicare."



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In late August or early September, 1978, ABC was invited by the Select Committee to cover the investigation and subsequent hearing as a national news event, and to set up hidden cameras to record undercover sessions with agents and to interview witnesses who would be testifying before the Committee.

It appears that the broadcast of ABC's three-part series on the "World Nightly News" was timed to coincide with the Select Committee's hearing conducted on November 28, 1978 and the issuance of the Staff Study report of the same date, which sets forth the results of the Staff Study investigation. Portions of the report were made available to ABC prior to November 28, 1978.

The 444-page report, entitled: "Abuses in the Sale of Health Insurance to the Elderly in Supplementation of Medicare: A National Scandal," contains the results of a 6 month investigation. According to the Staff Director, Robert S. Weiner, and Special Counsel, Val J. Halamandaris:

> "This study [was] the first detailed national investigation of the problem. Every State department of insurance and the great majority of companies selling Medicare supplemental insurance policies to the elderly have been surveyed. For the first time, large numbers of Senior Citizens have been asked about their problems with such policies. In addition, the Committee conducted investigations in 9 States and the District of Columbia ... which together account for half of America's 23 million aged. Using volunteer Senior Citizen investigators, we developed firsthand information about how some companies take advantage of the fearful aged." (See Select Committee on Aging, Staff Study Report, Exhibit E to Osmer affidavit in support of motion).



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The report details the procedures used and the information obtained from questionnaires mailed to every State department of insurance, interviews with five State insurance commissioners and their staffs, a review of all books, periodicals and newspaper references found in the Library of Congress on such insurance, a review of hearings and reports on the subject by congressional committees and administrative agencies, correspondence with all insurance related professionals and trade organizations and a review of all reports and documents provided, correspondence with Senior Citizen organizations asking for their experience with Medicare supplementary insurance, a review of insurance fraud and abuse files of the U.S. Postal Service investigators, every congressional office was asked to save and forward complaints for a period of one month. The staff drafted a questionnaire sent to 250 insurance companies asking for their experience with Medicare supplementary insurance and tabulated the replies, interviewed numerous insurance agents, and staff members obtained jobs as trainees accompanying licensed agents to observe the practices of the agents in the sale of insurance to the elderly, and recruited senior citizens as temporary investigators to test agents and their tactics.

The November 28, 1978 Staff Study report concluded and states in relevant part: "As a result of this investigation, the Committee staff concluded that there are serious abuses in this field which are widespread and require remedial action by State and Federal lawmakers (Report, p. 5).... The unvarnished truth is



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that while these companies talk in terms of the best interest of the elderly, they are in reality conspiring to rob them of their meager dollars. The elderly who sought to buy hope, health, and security, are left with empty pockets, anger and further disillusionment. That these practices have gone unnoticed for the past several years is a national scandal only slightly less in magnitude than the schemes of the avaricious companies and their greedy agents." (Report, p. 318).

We turn next to the broadcasts of ABC's three-part series on "Insurance Fraud", telecast on the "World News Tonight" on November 27, 28 and 29, 1978. This court has reviewed the tapes, outtakes and transcripts of the series.

It is evident that only a relatively small portion of the vast amount of information and material in ABC's possession, obtained from the Select Committee and as a result of its own investigation, could be used in the series. The time constraints imposed on commercial television, particularly on a national television network news program, require the exercise of editorial judgment as to what goes out on the air.

The ABC personnel directly responsible for the series were veteran correspondent Margaret Osmer, who was the on-the-air reporter, producer Karen Burns, and Vice President/Executive Producer of "World News Tonight" Av Westin. Also involved were "anchors" Max Robinson and Frank Reynolds, who did the lead-ins and closing statements, before and after each segment of the series.



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Plaintiff was not mentioned at all in the November 27, 1978 segment, which was an overview of the Select Committee's Staff Study investigation and report, and a preview of the Committee's hearing to be held the next day, November 28, 1978.

In this first segment, ABC described the abuses found by the Committee Staff as "massive fraud," and charged that there were unscrupulous companies and agents "deceiving, cheating, literally stealing from the people they are meant to help." In support of these charges, brief portions of interviews with volunteer Committee undercover senior citizen investigators and an insurance company agent, who admitted wrongdoing in the sale of insurance to the elderly, were shown.

The second broadcast on November 28, 1978 focused on plaintiff, the acknowledged world-wide leader in the sale of cancer insurance and described by some as the fastest-growing insurance company in the world. Portions of a long sales presentation or "pitch" by one of plaintiff's agents to Select Committee undercover investigators, and taped by ABC's hidden cameras, were shown. Plaintiff's agent was clearly and forcefully preying on the fear of cancer in his pitch. Also shown were portions of an interview with plaintiff's chairman, John B. Amos, at plaintiff's home offices in Columbus, Georgia, during which Amos said:

> "We don't have to sell fear. Fear is there. It's being promoted by the press." And, then, "So I don't think we're playing on fear. We are giving reassurance to people who already are dreadfully afraid of something. We're giving them at least financial security against it."



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Osmer said that plaintiff sold approximately 5,000 cancer policies a day, "making a very healthy profit on America's most dread disease." She described plaintiff as the fastest growing insurance company in the world.

There was also an interview with Kathy Gardner, a Committee staff member, who was a former sales trainee of plaintiff, and, herself, a victim of cancer. In Osmer's interview of Gardner, they discussed what Gardner would have received in benefits from plaintiff had she been one of plaintiff's policyholders. Gardner asserted that she would have received a total of $160.00 from AFLAC for her bills of $4,000.00. Osmer then stated that the better companies will pay 80 cents or more in benefits for every dollar of premium and that AFLAC "pays an average of 43 cents on each dollar."

Osmer concluded, "The issue Congress must consider is whether cancer policies like those sold by American Family Life fill a necessary gap in available medical coverage, or whether they play on people's fears with questionable promises of financial security and peace of mind."

The third or final segment of the three-part series, telecast on November 29, 1978, was a summary or recapitulation of the earlier broadcasts. Anchor Frank Reynolds began: "Tonight we have the third in our series of Closeup reports on rip-offs in sales of health insurance to the elderly. In tonight's report correspondent Margaret Osmer has some practical advice."



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Next, selected portions of the earlier broadcasts were replayed interspersed with comments by Osmer, who said: "The investigation has turned the spotlight on the abuses in the sale of supplemental health insurance. But it will take time to find effective safeguards against these illegal and unethical tactics. In the meantime, ABC news suggests you protect yourself by looking out for these subtle, but successful tricks in the sale of insurance..."

Osmer pointed out sales techniques which she described as "illegal," including a representation that the salesman was from or somehow connected with Medicare, requiring that the premium check be made out to the agent, selling a different policy from the policy the senior citizen thought had been bought ("switching") and overloading. She recommended a number of self-help procedures, including that senior citizens check on the loss/benefit ratio record of the company and that the company selected should pay at least 60 cents in benefits for every premium dollar. Finally, they were urged to carefully review policy provisions, including benefits, making sure that the policy does not exclude preexisting conditions, or that the old policy does not lapse before the new one becomes effective (where a policy is being replaced).

Osmer concluded with these observations:

> "Medicare will pay on the average thirty-eight percent of your medical bills. If you are able to afford it, supplemental health insurance can substantially defray the other sixty-two percent. However, no insurance will pay for everything. But if you will keep alert to the



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malpractices we've cited, and keep yourself well-informed, supplemental health insurance can be a good investment and not lost money."

Anchor Max Robinson then said: "There are almost two thousand insurance companies in America, and the names are often very similar. For example, the company mentioned in ABC News Report last night, American Family Life Assurance of Georgia is in no way connected with American Family Insurance Group of Wisconsin. It's best to check the exact names and reputations with your local consumer affairs office."

Though a number of disputed factual errors were made in the ABC series, such as that AFLAC is the fastest growing insurance company in the world -- plaintiff says in the U.S. -- and was selling 5,000 policies a day in 1978 instead of 3,000 as conceded by plaintiff, or that the elderly were being ripped off to the tune of $2 billion a year instead of $1 billion a year as was estimated by the Staff Study report (some errors originated in the Staff Study report and were repeated by defendants in good faith), these errors were insignificant and irrelevant to the main thrust of the broadcasts. By and large, the series was a fair and true report of the results of the unprecedented and exhaustive investigation conducted by the Select Committee on Aging as set forth in the Staff Study report. This court, as previously noted, reviewed all of the material used by ABC in the series, including the tapes of the broadcasts, outtakes and the transcripts, and



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finds that every material and significant statement or charge made by ABC was amply supported by the record, as set forth and documented in the Staff Study report.

Under these circumstances, the ABC three-part series, which is the subject of this lawsuit, was absolutely privileged under New York's Civil Rights Law, Section 74, which provides:

> "A civil action cannot be maintained against any person, firm or corporation, for the publication of a fair and true report of any judicial proceeding, legislative proceeding or other official proceeding, or for any heading of the report which is a true headnote of the statement published.
>
> "This section does not apply to a libel contained in any other matter added by any person concerned in the publication; or in the report of anything said or done at the time and place of such proceeding which was not a part thereof."

In Holy Spirit Ass'n v. New York Times, 49 NY2d 63, 67, which was a suit for libel against the New York Times stemming from a Times report of a congressional committee's investigation of the Unification Church, Jasen, J., writing for a unanimous Court of Appeals said:

> "For a report to be characterized as 'fair and true' within the meaning of the statute, thus immunizing its publisher from a civil suit sounding in libel, it is enough that the substance of the article be substantially accurate. As stated by this court in Briarcliff Lodge Hotel v. Citizen-Sentinel Publishers, (260 NY 106, 118):
>
> > '[A] fair and true report admits of some liberality; the exact words of every proceeding need not be given if the substance be substantially stated.' (citations)" (See also Freeze Right v. City of New York, 101 AD2d 175, 181-183 [1st Dept., 1984]; and Schermerhorn v. Rosenberg, 73 AD2d 276, 290 [2d Dept., 1980]).



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The court in Holy Spirit Ass'n, in affirming the Appellate Division, First Department's order (68 AD2d 833), which affirmed Special Term's order granting summary judgment to the defendant dismissing the complaint (99 M2d 125), held (p. 68):

> "Our conclusion today rests upon the realization that newspaper accounts of legislative or other official proceedings must be accorded some degree of liberality. When determining whether an article constitutes a 'fair and true' report, the language used therein shall not be dissected and analyzed with a lexicographer's precision. This is so because a newspaper article is, by its very nature, a condensed report of events which, must of necessity, reflect to some degree the subjective viewpoint of its author. Nor should a fair report which is not misleading, composed and phrased in good faith under the exigencies of a publication deadline, be thereafter parsed and dissected on the basis of precise denotative meanings which may literally, although not contextually, be ascribed to the words used."

Thus, it seems clear to this court, that the holding in Holy Spirit Ass'n v. New York Times, 49 NY2d 63, supra, is fully dispositive, and defendants' motion for summary judgment dismissing the complaint must be granted.

Though not necessary to this court's determination, this court has considered defendants' other arguments in support of the motion for summary judgment, such as that the series was not substantially false and was broadcast without actual malice.

It is clear that the statements made in the broadcasts, concerning abuses in the sale of supplemental health insurance to the elderly, cancer insurance and the plaintiff, are amply supported in the record, either from the Staff Study report or defendants' own investigation, which was corroborative of the Staff Study report (see Gaeta v. New York News, 62 NY2d 340). Further, defendants are entitled to the benefit of the actual



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mal.. standard inasmuch as plaintiff is either an all-purpose public figure or a limited-issue public figure, and there is insufficient proof of convincing clarity of actual malice by defendants (see Roche v. Hearst Corp., 72 AD2d 245, aff'd 53 NY2d 767), or that defendants' material statements were in fact false or substantially false (see Rinaldi v. Holt, Rhinehart & Winston, Inc., 42 NY2d 369, 380).

Accordingly, plaintiff's complaint, alleging causes of action for defamation, libel and alternatively prima facie tort, and seeking compensatory and punitive damages totalling $175 million, is dismissed. (See Springer v. Viking Press, 90 AD2d 315 [1st Dept., 1982]; Belsky v. Lowenthal, 62 AD2d 319, aff'd 47 NY2d 820).

Settle order.

DATED: MAY 20 1983

J. S. C.



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